Redstone MENTAL WELLNESS
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AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

I authorize_____
(Name and contact information of facility/health care provider you wish to release information)

To release information requested for: _____ **D.O.B.** _____
(Name of person making request) (Date of Birth)

To: Caroline Jones Redstone, DNP, PMHNP-BC, CNM **(f) 503.719.8865** **(p) 503.719.8865**

For the purpose of: _____

By **INITIALING** the spaces below, I specifically authorize the release of the following records, if such records exist:

___ All hospital records (including nursing records and progress notes)
___ Transcribed hospital reports ___ Pathology reports ___ Other (Explain Below)

___ Medical records needed for continuity of care ___ Diagnostic imaging reports _____
___ Most recent five-year history ___ Clinician Office Chart notes _____
___ Laboratory reports ___ Dental records
___ Emergency and Urgency care records. ___ Verbal communications

___ Please send the entire medical records, excluding psychotherapy notes, to the above-named recipient.
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*Psychotherapy notes are protected and requirement to disclose these records varies by state. A consultation with Caroline Jones Redstone, DNP, PMHNP-BC, CNM is strongly recommended prior to receiving mental health records.

I authorize the information listed below to be used, disclosed, or received by placing my **INITIALS** next to the information:

____ *HIV/AIDS - related records (Copies will not be released to inmates while incarcerated)
____ *Genetic testing information
____ * Mental Health-list specific info requested _____
____**Alcohol and Drug information

**PROHIBITED RE-DISCLOSURE: This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

* *Must be initialed to be included in documents. Records will not be released without your initials specifying that you have granted this specific release authority.*

This authorization is limited to a worker's compensation claim injuries of:_____

My signature indicates that I authorize the disclosure of the above information and understand the following:

- I understand that I may choose not to sign this authorization and that my choice not to sign will not be a basis to affect my ability to obtain treatment or my eligibility for health care benefits.
- I understand I can cancel permission to use and disclose my information at any time in writing. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 365 days from the date of signing. This authorization is limited to the following time period:_____
- I understand this change will not affect information that has already been shared.
- **I understand that federal and state law protects my health information. However, my information could be shared with agencies or businesses that may not be covered by this law.** They could then share my information with others. I understandthat they cannot share information regarding HIV/AIDS, mental health treatment, alcohol and drug treatment or genetic testing unless I give them permission by initialing this permission above or as otherwise permitted by law.

_____ _____
(Signature of Patient) (Date)

_____ _____
(Signature of legal/personal representative authorized by law)