

CARLA HELLEKSON, MD, PLLC

PSYCHIATRY & SLEEP MEDICINE

1300 - 114th Avenue S.E., Suite 102, Bellevue, WA 98004

www.drhellekson.com

Phone 425-688-1888

Fax: 425-696-0083

AUTHORIZATION TO EXCHANGE PROTECTED HEALTH INFORMATION (PHI)

I authorize *Carla Hellekson, M.D., PLLC* to release / obtain information from the records of:

Patient Name: _____ Date of Birth: _____

INFORMATION TO BE EXCHANGED WITH:

Organization/Individual: _____

Mailing Address: _____

Telephone: _____ Facsimile: _____

I authorize my records to be faxed to the number provided above. **Patient Initials:** _____

INFORMATION TO BE EXCHANGED:

- Sleep Evaluation, PSG Reports, and Outpatient psychiatric evaluation PT/OT reports
Progress notes
- Inpatient psychiatric discharge summary Psychological testing/assessment Laboratory/test reports
- Summary of medical or psychiatric history and treatment, including progress notes Psychiatric treatment/termination summary Chemical dependency records
- Crisis plan Treatment plan All records
- Progress notes for dates: _____
- Psychiatric medical notes for dates: _____
- Other: _____

FOR THE PURPOSES OF:

- Participation in psychiatric evaluation and/or treatment services
- Coordination of care between multiple providers
- Transfer of care to a new provider
- Other (please specify): _____

I understand that only the patient who has consented for care (including minors 13 years of age and older) can authorize for release of records. I understand that these records may contain information relating to HIV/AIDS, sexually transmitted diseases, and/or drug/alcohol abuse. I give my specific authorization for these records to be released. I understand that authorizing the disclosure of this health information is voluntary. I do not need to sign this form in order to assure treatment or payment. I understand that I can cancel this authorization at any time by writing to *Carla Hellekson, MD, PLLC*. I understand that once the information has been released according to the terms of this authorization that the information cannot be recalled. I understand that any disclosure of information carries with it the potential for further release or distribution by the recipient that may not be protected by federal confidentiality rules. I may cancel this authority at any time, except to the extent that action has already been taken. To revoke Authorization to Release Patient Health Information, I must do so in writing. Unless I cancel earlier, this authorization will expire when treatment with Dr. Hellekson has ended or one year after date of last visit, unless otherwise specified here: ___

Patient Signature: _____ **Date:** _____

The authorization below is given on the patient's behalf because the patient is either a minor or unable to sign.

Name: _____ Relationship to Patient: _____