Authorization to Release Confidential Information

I authorize the verbal and/or written release and exchange of confidential medical (including mandated communicable disease reporting, psychological, psychiatric, prescription medication, drug/alcohol, vocational, suspected child or elder abuse and/or other information). This release is limited to exchanges between Dr. Sarah Harper and the following individuals or organizations including law enforcement, the justice system, and other government agencies.

1. Friend or family member that Dr. Harper may contact if you are unable to be reached (for the purposes of making sure you are ok, and requesting that you call the office): ­­­­

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Medical insurance company for prior authorizations/ billing: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Other treating physicians including your primary care doctor and any specialists you see (for the purposes of obtaining lab results and discussing medications if necessary):

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Psychotherapist (if applicable, for the purpose of coordinating care): \_\_\_\_\_\_\_\_\_\_\_\_\_

Subject to the following exclusions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that I can revoke this consent at any time by informing the above parties in writing

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_