Niels Nielsen, MD
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Authorization for Release of Health Information (including Mental Health and Alcohol/Drug Treatment information) and/or Records

I, _____, Date of Birth: _____, hereby authorize Niels Nielsen, MD, to have **bilateral** exchange of information that is contained in my evaluation and/or medical record with:

Name: _____ Facility: _____
Address: _____
Phone: _____ Fax: _____

under the conditions listed below:

1. ____ I authorize to release and discuss information related to my care received at this office without limitations, including psychiatric/medical/alcohol/drug abuse evaluation, treatment or discharge summary

OR

2. ____ I authorize to release and discuss information related to my care received at this office, including psychiatric/medical/alcohol/drug abuse evaluation and treatment, limited to:
   ____ Progress notes ____Psychological testing ____Educational testing
   ____ Lab studies ____ Medical tests/studies ____Other:

Purpose or need for such disclosure:

____Coordination and continuity of care,

OR - Purpose: _____

3. This consent is subject to revocation at any time except to the extent that action has been taken in reliance thereon. If not previously revoked, this consent will terminate upon

   □ completion of treatment at this office
   OR
   □ other (specify date, event or condition: _____
   _____

4. An additional consent must be obtained for any other transfer or disclosure of this information.

5. I understand that I may receive a copy of this release.

_____ _____
Signature of patient, parent, guardian Date

_____ _____
Witness (if adult patient unable to sign) Date