

JoEllen H. Butler, PsyNP

Authorization for Release of Information (ROI)

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Patient Name: _____ **Date of Birth:** _____

INFORMATION ABOUT YOU CANNOT BE EXCHANGED WITHOUT YOUR CONSENT. Your signature on this release authorizes you or your provider to obtain or release medical records or information regarding your care. For the purpose hereof, "Medical Records" includes all confidential HIV/AIDS-related information, confidential communicable disease-related information, confidential alcohol or drug-abuse related information, and confidential psychological, behavioral health, medical, and educational information and data.

I HEREBY AUTHORIZE	☐ Release to	☐ Request from	☐ Release AND Request
JoEllen H. Butler, PsyNP	Name: _____		
Phone: 480-787-9384	Address: _____		
Fax: 480-940-3922	City/State/Zip: _____		
Email: joellenbutlerpsynp@gmail.com	Phone: _____ Fax: _____		
	Email: _____		

Purpose: This release is for the purpose of diagnosis, treatment planning, follow-up, subpoena for records, coordination of care, employment, and/or any reason listed below:

Information to be Released:	☐ Entire Record	☐ Progress Notes	☐ Patient Care Summary
☐ Medications	☐ Alcohol/Drug History	☐ Disability/Related Paperwork	☐ Health Condition Letter
☐ Other (Specify): _____			

The following **limitations/exceptions** to the release of this information apply (if none, write "none"):

Expiration: This authorization expires 90 days after completion of treatment, or upon the following earlier date/event:

_____ whichever occurs first, unless revoked sooner in writing.

Redisclosure

I understand that information disclosed under this authorization, including any substance use disorder treatment records protected under 42 CFR Part 2, may not be further disclosed by the recipient without my written consent, unless otherwise permitted by law. A general authorization for the release of medical or other information is not sufficient for this purpose.

Acknowledgement

I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any given time, except to the extent that action based on this authorization has already been taken (such as records already shared while this authorization was in effect). Any disclosure of medical record information by the recipients is not authorized except when implicit in the purposes of this disclosure.

Printed Name of Patient or Legal Guardian

Date

Signature of Patient or Legal Guardian

Relationship to Patient (if applicable)