Avant Mental Health
648 Chetco Avenue
Brookings, Oregon, US - 97415-8010

Release of Information

Avant Mental Health LLC
Kellie Creaser, DNP, PMHNP, FNP
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This document gives Avant Mental Health LLC and Kellie Creaser, DNP, PHMNP, FNP permission to communicate with the entities documented on this release.

Authorization to Release and Obtain Confidential Records and Information

A. Identifying information about me/the patient

Name of Patient *

Date of Birth *

Current Phone Number *

B. Because I believe it is in my/our best interest, I authorize Avant Mental Health LLC and Kellie Creaser DNP, PMHNP, FNP to release and/or exchange the following personal health information:

(1) Previous Treatment History * ☐ Yes ☐ No

(2) Medication History * ☐ Yes ☐ No

(3) Previous health assessments * ☐ Yes ☐ No

(4) Treatment at Avant Mental Health LLC (including but not limited to psychiatric care, psychotherapy, medication list) * ☐ Yes ☐ No

(5) Assessments with diagnoses, prognoses, and recommendations, and all similar documents * ☐ Yes ☐ No

(6) Social, family, developmental histories * ☐ Yes ☐ No

(7) Any other record necessary for facilitation of treatment and/or safety of client. * ☐ Yes ☐ No

C. I authorize the release and/or exchange of said information to the following agency (health provider, therapist, employer, lawyer, school, etc)

Name of Provider and/or organization: *

Address: *

Phone/Fax: *

D. I authorize the transfer of these records for the following purpose(s) or uses:

(1) Further mental health evaluation, treatment, or care
(2) Treatment planning
(3) Qualification for services or benefits
(4) General Coordination of Care

E. I understand that this Authorization is subject to revocation/withdrawal by me at any time in writing to Kellie Creaser DNP, PHMNP, FNP, except to the extent that action has already been taken to release this information. This Authorization shall remain valid unless revoked. I have a right to inspect a copy of the health information to be released and if I do not sign this Authorization, the institution named above will not release my health information. I authorize the releases of information to be conducted over telephone, email, text message, video chat and/or face to face, or faxes.

F. My consent is fully voluntary. If I refuse to sign this form, I understand that it will not adversely affect my ability to receive health care services, reimbursement for services, enrollment in a health plan or eligibility for health benefits.

G. I understand that the Source of the information (Avant Mental Health LLC) has no control of it after it has left the Source's premises (i.e. shared by the receiving entity).

Name of Patient or Guardian *

Signature of Patient or Guardian *

Date: *

Redisclosure: Notice is hereby given to the patient or legal representative signing this Authorization that Avant Mental Health LLC and Kellie Creaser DNP, PMHNP, FNP cannot guarantee that the Recipient receiving the requested health information will not redisclose any or all of it to others. Notice is hereby given to the Recipient that law prohibits the redisclosure of any health information regarding drug and/or alcohol abuse, HIV and mental health treatment.