FAIRBANKS PSYCHIATRIC AND NEUROLOGICAL CLINIC, P.C.

CONSENT FOR RELEASE/EXCHANGE OF INFORMATION

(Please fill in completely)

Neurological Psychiatric Psychotherapy
(please circle)

Patient Name: _____

Date of Birth: _____ Social Security #: _____

I hereby authorize the Fairbanks Psychiatric and Neurological Clinic to:

_____ Release information to: _____ Obtain information from: (Check both for reciprocal release)

Person/Agency/School: _____

Address: _____

City/State/Zip: _____

Phone Number: _____ Fax Number: _____

Information Requested:

____ Outpatient/Inpatient Records ____ Hospital Records ____ School Records ____ Verbal Information

Y / N	Diagnosis/Work Up Notes	Y / N	Intake/Case Notes/Treatment Plans
Y / N	Psychiatric Evaluations	Y / N	Substance Abuse Treatment
Y / N	Termination Summary	Y / N	Labs/X-rays/MRI's
Y / N	Mental Health Assessment	Y / N	Other: _____

Purpose of Information:

_____ Treatment Planning
_____ Continued Treatment
_____ Coordinate Treatment
_____ Legal Use
_____ Employment/Benefit Assistance
_____ Other (specify) _____

Must Initial for disclosure of:

_____ Psychiatric Information
_____ Psychotherapy Notes
_____ Substance Abuse
_____ AIDS/HIV Information

This consent is good through _____ (maximum of one year) and is given voluntarily in writing for the above stated purpose and will remain in effect until the expiration date unless it is revoked earlier. This consent may be revoked at any time, in writing, though does not change any action taken between the date of original signature and date of revocation. This document contains information that is privileged and confidential. Know that the information contained herein may not be disclosed to others pursuant to applicable federal and state law. Additionally, information in this realease, is protected by federal confidentiality law 42 CFR Part 2.

Patient Signature: _____ Date: _____

Parent/Guardian: _____ Date: _____

Witness: _____ Date: _____

Please mail/fax the information requested to the following address or fax number:

Fairbanks Psychiatric and Neurological Clinic, PC
1919 Lathrop Street, Suite 220, Fairbanks, AK 99701
Phone: (907)452-1739 Fax: (907)452-2384

___ send for records ___ release records

___ send ROI only ___ file ROI only _____ Date ___ mailed ___ faxed ___ picked up