

Jeffrey J. Hansen, M. D.

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AUTHORIZATION FOR RELEASE OF INFORMATION

We can help you better if we are able to work with other agencies that know you. By signing this form, you are giving permission for this organization to share information about you.

Name: _____ D.O.B. _____

I authorize the following individual, Jeffrey J. Hansen, M.D., to exchange information with:

_____ at;

Phone: (____) _____ - _____ Fax: (____) _____ - _____

Address: _____

Including records of:

Check report	If Applicable, Date of Report	Check report	If Applicable, Date of Report
<input type="checkbox"/> Yes <input type="checkbox"/> No	Face Sheet _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychological Evaluation _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Admission History _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	X-Ray Reports _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Health Assessment _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lab Reports _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	History & Physical Exam _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Discharge Summary _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychosocial History _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Consultation by _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Social Service _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Consultation by _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Progress Notes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other _____
	From _____		
	To _____		Initials required for HIV testing/AIDS release _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Alcohol/Drug _____		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric _____		Information regarding sexually transmitted disease, including HIV testing and/or AIDS (date) _____

Purpose: The information exchanged will be used for evaluation, treatment planning, and coordination of services for me, or for other purposes as specified:

This permission is good for six (6) months or until: _____

I can cancel this at any time, but I understand that the cancellation will not affect any information that was already released before the cancellation. I understand that information about my case is confidential and protected by state and federal law. I approve the release of this information. I understand what this agreement means. I am signing on my own and have not been pressured to do so.

Client Guardian Parent Legal Custody

Signature

Date

Witness Signature

Date