FOR OFFICE USE ONLY	
☐ Scan ONLY	☐ EXPEDITE
☐ Initial evaluation	☐ Lab records
☐ Treatment records	☐ Medications list
☐ Last 3 visit notes	☐ EKG
☐ Other _________	

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AUTHORIZATION FOR RELEASE OF INFORMATION

I, ____ ____/____/_______
Printed Name Date of Birth

authorize the release of medical records between **Tracy Figlan, PMHNP-BC**, at the above address, and:

Name: ____

Address: ____

Phone: ___________________________

Fax: _____________________________

The information contained therein pertains to:

- ❑ Mental health care
- ❑ Medical care
- ❑ Substance use and treatment
- ❑ HIV status and/or testing
- ❑ Other: ____________________________

The method(s) of release of information may include:

- ❑ Verbal communication
- ❑ Written communication
- ❑ Photocopies and/or fax
- ❑ Electronic copy or access via a web-based portal

The purpose of this release is:

- ❑ To communicate regarding treatment and coordination of care (e.g., with primary care doctor or therapist)
- ❑ For use by a third party (e.g., insurance company, lawyer)
- ❑ Other: ____________________________

Information specifically excluded from this release, if any: _________________________________

I understand I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing. Unless otherwise revoked, this authorization will expire (PLEASE SELECT ONE):

- ❑ If I am no longer in treatment with a provider at Pondworks

  -OR-
- ❑ (1) year

  -OR-
- ❑ Specified length of time: _____________

Signed: ____ Date: _________________
(Patient or Legal Representative)

Printed Name: ____

V 2.0