



FOR OFFICE USE ONLY			
<input type="checkbox"/>	Scan ONLY	<input type="checkbox"/>	EXPEDITE
<input type="checkbox"/>	Initial evaluation	<input type="checkbox"/>	Lab records
<input type="checkbox"/>	Treatment records	<input type="checkbox"/>	Medications list
<input type="checkbox"/>	Last 3 visit notes	<input type="checkbox"/>	EKG
<input type="checkbox"/>	Other _____		

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 Medical Records Fax: (512) 367-5756

### AUTHORIZATION FOR RELEASE OF INFORMATION

I, \_\_\_\_\_ / /  
 Printed Name Date of Birth

authorize the release of medical records between **Hyojin Han, 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: \_\_\_\_\_