LAUREL HOLZE, PA-C, MPH
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NAPERVILLE, IL 60563
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REQUEST/AUTHORIZATION TO RELEASE CONFIDENTIAL RECORDS AND INFORMATION

Patient Name:_____ Date of Birth:_____

Address:_____ City, State, Zip:_____

Cell Phone:_____ Home Phone:_____

I hereby authorize Laurel Holze, PA-C, MPH to: (Check one or both)

- ❑ Send copies of your psychiatric record to (or discuss information with) the provider/person/facility below:
- ❑ Receive copies of your record from (or discuss information with) the provider/person/facility below:

_____ _____
Name of Provider/Person/Facility Address

_____ _____ _____
City, State, Zip Phone Fax

PURPOSE FOR THIS REQUEST:
❑ At the request of the patient/guardian ❑ Coordination of services ❑ Share/Receive Information Relevant to Treatment
❑ Attorney/Court ❑ Personal Use ❑ Continuity of Care ❑ Insurance Application ❑ Other: _____

TYPE OF RECORDS OR INFORMATION REQUESTED:
❑ Psychiatric Evaluation ❑ Progress Notes ❑ Discharge Summary ❑ Summary of Diagnosis and Treatment
❑ Medical History and/or Evaluation(s) ❑ Labs/Test Results_____
❑ Consultations/Evaluations ❑ Verbal exchange of clinical information ❑ Diagnosis ❑ Prognosis
❑ Other: _____

For the following dates of service:_____

I have a right to inspect a copy of any and all materials that I authorized to be disclosed. I understand that my records are protected under federal, state, and local regulations governing confidentiality and privacy of my treatment information, included but not limited to, the Health Insurance Portability and Accountability Act of 1996 ("HIPPA") and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke my consent in writing at any time, except to the extent of actions that have already been taken in reliance on it. Further, I understand that disclosure of information to individuals or entities that are not covered by HIPPA regulations, such as parents, spouses, children, significant others, is not protected by HIPPA prohibitions on disclosures.

This consent expires:
❑ 120 Days from the date of this consent, or ❑ On the following date, event, or condition: _____

_____ _____ _____
Patient Signature Printed Name Date

_____ _____ _____
Parent/Guardian Signature Relationship to Patient Date

_____ _____ _____
Witness Signature Printed Name Date