Erik Gustke, M.D., PLLC

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RELEASE OF INFORMATION: **Effective One year From (Today's Date): _____/_____/_____**

PATIENT NAME (Print): _____ DOB: _____/_____/_____

I AUTHORIZE DR. ERIK GUSTKE TO RELEASE INFORMATION TO and RECEIVE INFORMATION FROM:

THERAPIST: _____ Phone/Fax: _____

Address: _____

PRIMARY CARE: _____ Phone/Fax: _____

Address: _____

OTHER: _____ Phone/Fax: _____

Address: _____

INFORMATION THAT MAY BE RELEASED:

_____**Mental Health/Physical Information:** Which Includes: Presence and Progress in Treatment, Assessments, Diagnoses, Treatment Plans, Psychiatric Summary, Medication Records, Demographic Information
INITIALS

_____ **Drug and Alcohol Treatment:** Which Includes: Presence and Progress in Treatment, Assessments, Diagnoses, Treatment Plans, Psychiatric Summary, Medication Records, Demographic Information
INITIALS

_____ **Other:** _____
INITIALS

REASON: (☐) **Provide Continuity of Care** (☐) Personal Use (☐) Legal Purposes (☐) Social Security/Disability (☐) Insurance/Managed Care (☐) Other _____

DATES OF SERVICE: **(☐) ALL** **(☐) From** _____ **To** _____

I understand that my health information is protected under the federal regulations governing the Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2 that re-disclosure is prohibited, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 C.F.R. Parts 160 and 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. The information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer will be protected by the HIPAA Privacy Law.

1) review and understand the Notice of Privacy Practices;
2) this authorization is subject to revocation at any time, except to the extent that action has been taken in reliance on the authorization;
3) inspect and receive a copy of the material to be released;
4) request restrictions on how my health information is used and disclosed; and
5) receive a copy of this authorization and the Notice of Privacy Practices

This form has been fully explained and I certify that I understand its contents. I understand that (agency) may not condition treatment on obtaining this consent/authorization from me.

_____ _____/_____/_____
Signature of Patient (and Parent if patient is a minor) **Date**

_____ _____/_____/_____
Witness Signature **Date**