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Authorization for Release of Information

Patient's Name _____

I hereby authorize Dr. Shannon Caspersen to contact and obtain and/or provide my medical history and other related information to/from the following individuals/institutions for the purpose of medical care, which can include information such as labwork, psychological testing, medical and psychiatric history, treatment history, and written medical records:

Name:

Telephone:

I understand that this correspondence may involve a conversation or a transfer of written material and that I have the right to revoke the above authorization at any time.

Signature: _____

Printed Name: _____

Date: _____

Notice of Confidentiality

It is understood and agreed to by the recipient of the document or communications requested above that this is privileged information within the doctor-patient relationship, and is confidential material by law. Further disclosure or release of the documents or their contents by the recipient of any other party is not authorized without the above patient's written consent. Furthermore, it is understood that the patient may withdraw his/her consent to this release at any time.