Kerstin Helgason, NP
8339 Church Street, Suite 114, Gilroy, CA 95020
Phone: 408-767-2337 Fax: 415-376-4572
Email: info@gilroymentalhealth.com

AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

_____ _____
NAME OF PATIENT WHOSE INFORMATION WILL BE DISCLOSED DATE OF BIRTH

_____ _____
ADDRESS PHONE NUMBER

I consent to and authorize the following people or entities to use, disclose, and exchange health information between:

Kerstin Helgason, PMHNP
8339 Church Street, Suite 114, Gilroy, CA 95020
Phone: (408) 767-2337 Fax: (408) 767-2338

AND

_____ _____
NAME OF INDIVIDUAL/ENTITY SHARING INFORMATION RELATIONSHIP

_____
ADDRESS, CITY, STATE, ZIP CODE

_____ _____ _____
PHONE FAX EMAIL

Please *initial* all information to be released or exchanged:
____ All records and all verbal or other communication
____ Evaluations and Progress notes
____ Admission and discharge summaries
____ Lab results, ____ Imaging results, ____ Other results_____
____ All information for verbal or written coordination (without records being exchanged)
____ Other: (eg: letter, specific dates) _____
DESCRIBE INFORMATION TO BE USED/DISCLOSED

For the purpose of:_____

Additional Instructions:_____

***All records will contain this information, please initial both when requesting release of information.**

*_____ Mental Health/Psychiatric information
*_____ Alcohol/Substance Use/Chemical Dependency information
_____ Genetic testing information
_____ HIV/AIDS information

SIGNATURE: I have read and understand this authorization and, unless revoked, this authorization expires 2 years after the date signed. Authorizations may be revoked in writing at any time, except any action already taken cannot be undone.

X_____
SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

_____
LEGAL GUARDIAN'S RELATIONSHIP TO PATIENT