Lori J. Olson, P.M.H.N.P.
4511 SE Hawthorne Blvd. Suite 215
Portland, OR 97215
503 224 6446
503 224 8878 Fax

Authorization for Release of Information

Patient's Name:_____

Patient's Date of Birth:_____

I, _____ authorize **Lori J. Olson, PMHNP** to obtain information from and release information to:

Provider's Name:_____
*Address :*_____
_____
*Phone # :*_____ *Fax #:*_____

I specifically authorize release of the following:

Please Sign Your Initials As Appropriate

___ Drug/Alcohol Abuse Treatment
___ Psychiatric and Mental Illness Treatment
___ Human Immunodeficiency Virus, Antibody Test and Results
___ Discharge Summary
___ History and Physical Assessment
___ Emergency Room Reports
___ Lab Results
___ EKG Reports
___ Intake and Psychosocial Reports
___ Coordination of Care
___ Other – Specify:_____

The purpose of such information is: ***patient care***
I expressly and voluntary authorize the disclosure of my medical record for the purpose stated above. I further understand that I am not giving my permission for any disclosure other than described above. I understand that I may revoke this authorization at any time, except to the extent action has been taken on this authorization.

This consent may be revoked by me at any time buy may not be revoked in respect to information provided or actions taken prior to time of revocation. Unless expressly revoked earlier, expires one year from signature date.

Patient's Signature:_____ Date:_____

Parent/Guardian Signature:_____ Date:_____