PATHWAYS
8217 W 20th Street, Suite A
Greeley, CO 80634
(970) 356-3100 Fax (970) 356-4827

Authorization for Release of Protected Health Information

For: **PATIENT NAME:** _____

Date of Birth: _____ Phone#: _____

From the Records of:

☐ Jeff Huff, Psy.D., M.D. ☐ Russ Johnson, M.D. ☐ Joanna Branum, M.D. ☐ Barry R. Lindstrom, Ph.D.
☐ Nathan K. Swisher, Psy.D. ☐ Antoinette "Toni" Pasquale, BCPC, LPC ☐ Nichole Miller, LPC

INFORMATION TO BE RELEASED:

☐ Initial Evaluation / H &P	☐ Treatment / Progress Notes	☐ Discharge Summary	☐ Psychiatric / Mental Health
☐ Medical Records	☐ Drug and Alcohol Dx / Tx	☐ Lab / Path Reports	☐ Special Education / IEP
☐ Psychological Testing	☐ Family / Marital Therapy	☐ Family Evaluation	☐ DHS / Court / legal records
☐ Psychological Evaluation	☐ Disability Evaluation	☐ Other: _____	

I hereby authorize Pathways to: ☐ ***Release*** the information / records indicated above ***to***:
☐ ***Obtain*** the information / records indicated above ***from***:

Name: _____

Address: _____

City/State/Zip: _____ Phone: _____

Fax: _____

For the purposes of: ☐ Shared Record Keeping ☐ Case Management / Continuity of Care ☐ Legal
☐ Insurance ☐ Employer ☐ Other: _____ ☐ Other: _____
Via: ☐ Written Records ☐ Verbal Communication ☐ E-mail / fax ☐ Staffings ☐ Testimony

EXPIRATION OR REVOCATION OF AUTHORIZATION: I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken to comply with it. Without my expressed revocation, this authorization will **automatically expire on December 31, 2024,** or **one year from the date** of my signature whichever is later.

I understand that the records to be released may contain information related to substance/alcohol abuse, psychiatric or psychological conditions, which may be protected by Federal Confidentiality Regulations, 42 CFR Part 2.

A copy of this authorization (including facsimile copy) may be used with the same effectiveness as the original.

I have read the above and understand the terms and conditions of this Authorization. I release Pathways and the above-named practitioners / agencies from any liability in complying with this Authorization.

_____ _____
Patient or authorized representative / Relationship to Patient Date

_____ _____
Witness Date

NOTICE TO RECIPIENTS: This information has been disclosed to you from records which are protected by federal law. Regulations prohibit your further disclosure without the specific written consent of the person to whom it pertains.