# Authorization to Release/Obtain Patient Information

**Doug Ikelheimer MD | Board Certified in Psychiatry and Addiction Psychiatry**
Office: 720-627-5888 | Fax: 720-708-4896
www.homepsychiatry.com | homepsychiatry@gmail.com

| **Obtain From: (Release Entity)** | **Release To: (Receiving Entity)** |
|---|---|
| **Name:** | **Doug Ikelheimer MD** |
| **Address:** | **homepsychiatry@gmail.com** |
| **Phone:** | **Phone: 720-627-5888** |
| **Fax:** | **Fax: 720-708-4896** |
| **Email:** | |

**I hereby give the releasing facility cited above permission to disclose my individually identifiable health information as listed below. I understand that once this information is disclosed, it may no longer be protected by the Releasing Entity. I understand that this authorization is voluntary, that further treatment cannot be conditioned upon my signing this authorization, and that there me some cost associated with copying and submitting the records.**

**DATE RANGE OF SERVICES TO BE DISCLOSED (pick date range or write "ALL"):**

**DATE THIS CONSENT WILL EXPIRE (pick date or write "NEVER"):**

**Information to be Released (check all that apply):** **___ All**

___ Mental Health Records ___Medical Records ___ Drug/Alcohol Treatment

___Discharge Summaries ___History and Physical ___Clinical/Progress Notes

___Radiology Reports/Films ___Laboratory Information ___Genetic Information

___STD/HIV Information ___Immunization Records ___Operative Reports

___Electronic Communications Including Email and Texts

**Information is to be used for:**

___Continuity of Care ___Damage/Claim Information ___Personal Use OTHER:

**Authorization: I understand I can revoke permission to release medical records at any time. I understand that the written revocation must be signed and dated no later than the date of this authorization. A copy or facsimile of this form is to be considered as valid as the original.**

_____

**Hand written signature required.** Today's Date

_____

Print Name Date of Birth