ANNIE GRUMMEL WARD

PSYCHIATRIC MENTAL HEALTH NURSE PRACTIONER (PMHNP)

Name _____ D.O.B. _____

Current Address _____

I AUTHORIZE INFO RELASES TO/FROM

Annie Grummel Ward, PMHNP	+	_____
2187 SW Main Street Suite #101	+	_____
Portland, Oregon 97205	+	_____
503-894-9810 (PHONE)	+	_____
503-536-6719 (FAX)	+	_____

PURPOSE OF RELEASE

☐ To facilitate treatment & continuity of care
☐ To facilitate billing & reimbursement from insurance carriers
☐ Other (specify) _____

Permission to fax information: ☐ Yes ☐ No

I specifically consent to the faxing of my medical records. All faxed material will contain a confidentiality statement.

TYPE OF INFORMATION TO BE RELEASED

☐ General medical records – excluding protected records
☐ Specifical information only
  - o History & physical
  - o Medications/ therapy
  - o Lab, path, EKG
  - o Progress notes
  - o Consultations
  - o Accident or injury
  - o Discharge summary
  - o Other _____

Protected or sensitive information: I understand that certain information cannot be released without specific authorization as required by state/ federal law. By signing, I authorize the release of the following protected or sensitive information:

- Drug abuse diagnosis/ treatment
- Mental health/ treatment
- Neuropsychological assessment

Signature Date

This authorization is valid until therapy ends or until it is revoked.