JUNE PEDIATRIC CONSULTING

Holly Stafford DNP, ARNP, CPNP-PC
Pediatric Behavioral and Mental Health Services

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AUTHORIZATION FOR THE RELEASE OR EXCHANGE OF INFORMATION

This form authorizes Holly Stafford, DNP, ARNP to exchange (obtain, release, or share) protected health information regarding you/your child with the person or organization designated below. Please review and sign.

Organization/Person: ____

This authorization pertains to clinical information regarding:

Client's Name: ____

Date of Birth: ____

Address: ____

____

I, ____, authorize Holly Stafford, DNP, ARNP to exchange (obtain, release, or share) the following information regarding myself/my child.

___ Medical History
___ Medical Exam
___ Medical Records
___ Health Treatment Plan
___ Hospitalization Record
___ Discharge Summary
___ Psychiatric Evaluation
___ Psychological/Neuropsychological Assessment Data/Results

___ Mental Status Exam
___ Mental Health Treatment Plan(s)
___ Mental Health Progress Notes
___ Crisis Intervention Reports
___ Educational Records
___ Drug/Alcohol Assessments/Records
___ Court/Agency Documents

__ Other (specify): ____

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Client Signature: ____________________________________ **Date:**______________________

The authorization below is given on the client's behalf because the client is a minor or unable to sign.

Name: ____________________________ **Relationship to Client:**________________________

Signature: ____________________________________ **Date:**___________________________

*****Patients aged 13-18 must sign this form to release information regarding mental health. This is required by Washington State and the parent's/guardian's signature is not acceptable.***