DR. TAMI JOLLIE-TROTTIER, PHD, PLLC
RELEASE OF INFORMATION (TWO WAY AUTHORIZATION)

NAME OF CLIENT: **DOB:**

I authorize Dr. Tami Jollie-Trottier, 1015 Hospital Rd, Suite A, Belcourt, ND 58316

To release to:

(Name of Individual or Organization to Receive Information; include address, fax, and phone number if applicable) AND/OR

I Authorize:

(Name of Individual or Organization to Release Information)

release to: Dr. Tami Jollie-Trottier, 1015 Hospital Rd, Suite A, Belcourt, ND 58316

I am requesting and authorizing the release of the following information: ☐Two-way Ongoing Written (incl. email) ☐Two-way ongoing Verbal (incl. email) ☐Electronic Protected Health Information ☐Psychological Testing ☐Neuropsychological Evaluation ☐Specify Other_____ ***I am requesting and authorizing the release of the above information for the following purpose:*** ☐Diagnosis & Treatment ☐Legal ☐Disability ☐Vocational Rehabilitation ☐Insurance ☐School ☐Specify Other:_____

ALL RECORDS PERTAINING TO PSYCHIATRIC/MENTAL HEALTH, ALCOHOL AND/OR DRUG DEPENDENCY, AND OR HIV/HIV RELATED ILLNESS WILL NOT RELEASED UNLESS SPECIFICALLY AUTHORIZED BELOW IN WRITING.

I specifically authorize the release of the following records:

☐ Psychological _____(initials) ☐ HIV_____ (initials) ☐ Drug and/or Alcohol Dependency_____(initials)

☐**Check if applicable – Notice to Whomever Disclosure is made concerning addition records**

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the disclosure of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Notice: Except for information subject to 42 CFR Part 2, information disclosed to another entity may potentially be re-disclosed, in which case in may not be protected by state and federal law.

This authorization will remain effective until the following date, event, or condition: If no date, event, or condition is specified, this authorization will expire in one year.

1. This authorization remains in effect until the above date, event, or condition, unless specifically revoked by written notice to the individual or organization. I understand that this authorization may be revoked at any time. Any information released prior to my written revocation of this authorization shall not be breach of confidentiality.
2. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this authorization in order to assure treatment.
3. I understand that I may inspect or request copies of any information disclosed under this authorization and that I am entitled to a copy this authorization form once I have signed it.
4. I understand that if the individual or organization that receives the information is not a health care provider or health plan covered by federal privacy regulations the information described above may be disclosed and no longer protected by these federal regulations.
5. A photocopy of this authorization is as effective as the original

_____Date_____

(Print Name)

_____Date_____

(signature of Legal Guardian or Legal Representative) (relationship)

If patient is unable to sign, specify reason: Patient is: ☐Minor ☐ Incompetent ☐Disabled ☐Deceased

Legal Authorization: ☐Legal Guardian/Parent of Minor ☐Next of Kin ☐Power of Attorney

Distribution: ☐To agency/person from who information is sought ☐Requesting Agency ☐Client

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