Catalyst
BEHAVIORAL HEALTH

**Tracy List Kalnins, PhD.**
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## Authorization to Release and/or Receive Healthcare Information

Name of Patient: _____

Address: _____

Date of Birth: _____

I request and authorize Dr. Tracy List Kalnins to release and /or receive healthcare information:

_____
Name of Health Care Provider/Agency

_____
Address and Phone/Fax

Information requested (please check which):

| | | | |
|---|---|---|---|
| ☐ Medical history and physical | ☐ Social History | ☐ Medication Information | ☐ Psychological Testing |
| ☐ Psychological evaluation | ☐ Treatment Plan | ☐ Academic Records | ☐ Entire Record |
| ☐ Psychiatric evaluation | ☐ Discharge Summary | ☐ Hospital Records | ☐ Lab Reports |

Information may be used for evaluation, treatment, educational planning, follow-up, continuity of care or for further medical treatment. This authorization is good for one year from the date signed or for _____ days. I have reviewed this authorization form and confirm that it reflects my wishes to release/receive protected healthcare information. I understand that any disclosure of information carries with the potential for unauthorized redisclosure and the information may not be protected by federal confidentiality rules. By signing this document, I release Tracy List Kalnins, PhD., LLC from any liability resulting from this disclosure. I also have the right to revoke this authorization at any time and must do so in writing to the office manager at Catalyst Behavioral Health. I further understand that actions already taken based on this authorization, prior to revocation, will not be affected. A photocopy or fax of this document shall have the same effect as the original.

_____
Signature of Patient/Legal Representative

_____
Witness

_____
Date document signed