PREMIER PEDIATRICS

Natasha Wills 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 Natasha Wills 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 Natasha Wills 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 Assessment/Records
___ Court/Agency Documents
___ Other (specify): _____

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.