Kelly Yan
Psychiatric Mental Health Nurse Practitioner

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (ROI)

Client Name: _____ Date of Birth: _____

I authorize Kelly Yan PMHNP to release information to and to obtain information from:

Health care provider/therapist/interested party: _____

Clinic/organization/relationship: _____

Address: _____

Phone Number: _____ Fax Number: _____

Purpose of this request is to facilitate:
☐ Treatment & continuity of care ☐ Billing & reimbursement ☐ Scheduling ☐ Other: _____

Type of information to be released:
☐ Medical and Mental Health Records ☐ Specific Information: _____

Protected or sensitive information: By law, certain information cannot be released without specific authorization. I authorize the release of the following protected or sensitive information:

_____Mental health treatment _____ Alcohol or drug abuse treatment
_____Sexually transmitted diseases _____AIDS/HIV information _____Genetic testing

I understand that:

- I can cancel this authorization at any time by submitting a written request to Kelly Yan PMHNP.
- If the person or facility receiving your health information is not bound by HIPAA privacy rules, the information might be shared with others. See HIPAA Privacy Practices for more information.
- Information protected by Federal Confidentiality Rules 42CFR, Part 2, cannot be disclosed without my written consent unless otherwise specified in the regulation.
- Information sent to health care providers is free of charge. Information sent to other may incur a fee.
- Unless revoked in writing, this authorization expires 90 days after the termination of care.

Signature: _____ **Date**: _____

If signed by person other than client:

Name:_____ Relationship to client: _____

971-300-4254 | Fax: 503-200-1241 | kelly@kellyyan.net | www.kellyyan.net
1020 SW Taylor St. Suite 448 | Portland, OR 97205