Catalyst
BEHAVIORAL HEALTH

Authorization to Release and/or Receive Healthcare Information

Name of Patient: _____

Address: _____

Date of Birth: _____

I request and authorize Tracy List, Ph.D. to release and /or receive (please circle) 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, Ph.D., 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_____

Tracy K. List, Ph.D., LLC
2001 Pine Lake Road, STE 200 Lincoln, NE 68512
Phone (402) 261-8313 Fax: (866)321-6448
Creating Positive Change