Lisa J. Trigg, PhD, ARNP, PLLC

Psychiatric Evaluation, Consultation & Treatment

901 Boren Ave, Suite 1300
Seattle, WA 98104
Tele (206) 701 9456 Fax (866) 386 6061

AUTHORIZATION TO EXCHANGE PROTECTED HEALTH INFORMATION (PHI)

I authorize Lisa J. Trigg, PhD, ARNP to release/obtain information from the records of:

Patient Name: _____ **Date of Birth:** _____

INFORMATION TO BE EXCHANGED WITH

Organization/Individual: _____
Mailing Address: _____
Telephone: _____ **Fax:** _____
I authorize my records to be faxed to the number listed above. **Patient Initials:** _____

INFORMATION TO BE EXCHANGED

- ☐ **Sleep Evaluation, PSG Reports, and Progress notes**
- ☐ **Outpatient psychiatric evaluation**
- ☐ **PT/OT reports**
- ☐ **Inpatient psychiatric discharge summary**
- ☐ **Psychological testing/assessment**
- ☐ **Laboratory/test reports**
- ☐ **Summary of medical or psychiatric history and treatment, including progress notes**
- ☐ **Psychiatric treatment/termination summary**
- ☐ **Chemical dependency records**
- ☐ **Crisis plan**
- ☐ **Treatment plan**
- ☐ **All records**
- ☐ **Progress notes for dates:** _____
- ☐ **Psychiatric medical notes for dates:** _____
- ☐ **Other:** _____

FOR THE PURPOSES OF

- ☐ **Participation in psychiatric evaluation and/or treatment services**
- ☐ **Coordination of care between multiple providers**
- ☐ **Transfer of care to a new provider**
- ☐ **Other (please specify):** _____

I understand that only the patient who has consented for care (including minors 13 years of age and older) can authorize for release of records. I understand that these records may contain information relating to HIV/AIDS, sexually transmitted diseases, and/or drug/alcohol abuse. I give my specific authorization for these records to be released. I understand that authorizing the disclosure of this health information is voluntary. I do not need to sign this form in order to assure treatment or payment. I understand that I can cancel this authorization at any time by writing to Lisa J. Trigg, Ph.D.c, ARNP. I understand that once the information has been released according to the terms of this authorization, that the information cannot be recalled. I understand that any disclosure of information carries with it the potential for further release or distribution by the recipient that may not be protected by federal confidentiality rules. I may cancel this authority at any time, except to the extent that action has already been taken. To revoke Authorization to Release Patient Health Information, I must do so in writing. Unless I cancel earlier, this authorization will expire when treatment with Dr. Trigg has ended or one year after the date of last visit, unless otherwise specified here: _____

Patient Signature: _____ **Date:** _____

The authorization below is given on the patient's behalf because the patient is either a minor or unable to sign.

Name: _____ **Relationship to the Patient:** _____

_____ **Processed By:** _____

Lisa J. Trigg, PhD, ARNP, PLLC

Psychiatric Evaluation, Consultation & Treatment

901 Boren Ave, Suite 1300
Seattle, WA 98104
***Tele** (206) 701 9456 **Fax** (866) 386 6061*

FOR INTERNAL USE ONLY
Date Request Received: _____ _____