ALLISON HOLT & ASSOCIATES
CHILD, ADOLESCENT & ADULT PSYCHIATRY AND THERAPY
Change is within reach.

Allison Holt, MD
Angie O'Shea, MA, LMFT
NURSE Becky Orpen, RN

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261 School Avenue, Suite 220, Excelsior, MN 55331

Authorization Form

Patient Name: _____ DOB: _____

Telephone Number: _____

I hereby authorize Allison holt and Associates to: (choose one):

☐ Obtain copies of records from: ☐ Disclose copies of records to: ☐ Verbal/Written Contact:

Name: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

Information to be released (please check all that apply):

☐ History and Physical
☐ Emergency Room Report
☐ AIDS/HIV Related Illness/ Testing
☐ Diagnostic Interview
☐ Discharge Summary
☐ Laboratory Report
☐ Progress Notes
☐ Treatment Plan/Care Plan
☐ Medications
☐ Psychiatric Evaluation
☐ Chemical Dependency Information
☐ Other Information (Please specify below)

_____

Please indicate any restrictions (specify):

_____

I am requesting this information be released for the following purposes (must circle at least one):

☐ Continued Care ☐ Legal ☐ Patient's Request Insurance ☐ SSDI
☐ Other (Please specify below)

_____

I understand I may revoke this authorization by written request at any time to the address listed at the top of this form. This authorization will automatically expire one year from the date of my signature.

_____ _____

Signature of Patient/Legal Representative Date

_____ _____

Print Name of Legal Representative Legal Representative's Authority to Sign

Reason Patient is Unable to Sign (please check one): ☐ Minor ☐ Deceased ☐ Other: _____