



Permission for Release and Exchange of Information to

Redstone Mental Wellness, LLC; Phone:(503) 719.8865; Fax: (503) 384.2608

Client Name _____ Date of Birth _____ Phone # _____

Authorization for Caroline Jones Redstone, DNP, PMHNP-BC, CNM to request and/or disclose information, verbal or written including medical records, to the following provider/clinic (Name, address, phone, fax): _____

Please initial the applicable items below:

- _____ Mental health care including treatments
_____ Addiction and/or substance abuse
_____ HIV/AIDS, STDs

Please check next to all applicable items requested below:

- _____ Psychiatric evaluation
_____ Medication Records
_____ Treatment Plans
_____ Laboratory Data Including Drug Testing
_____ Social/Medical/Obstetric History
_____ Case Management Plans/Services
_____ History & Physical Exam
[checked] Verbal Communications
_____ Admission/Discharge Summary
_____ Other _____

State the purpose of disclosure of health care information to be released/obtained:

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment of HIV (AIDS virus), sexually transmitted disease psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed or treated for HIV (AIDS virus), sexually transmitted disease, psychiatric disorder/mental health, or drug and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing or treatment.

I understand that I may revoke this consent for release for medical records at any time except to the extent that action has been taken in reference to it. If you chose to revoke consent, it must be done in writing.

Client's name - Print sign/date Client's Signature