



Authorization to Release/Obtain Medical Information

Patient Name _____

Date of Birth: ____/____/____

I hereby authorize _____ at Oasis Mental Wellness, PLLC
to

___ **Release** protected health information to (either in verbal or written form):

___ **Obtain** protected health information from (either in verbal or written form):

Name: _____

Phone: _____ Fax: _____

Address: _____ City: _____

State: _____ Zipcode: _____

Information to be released or accessed in verbal or written form:

Dates of service: _____

___ All medical records including diagnostic evaluation, progress notes, phone calls, labs
consults, imaging reports, etc...excluding psychotherapy notes.

___ Medication records only ___ Labs and imaging studies only

___ Following specific only: _____



Purpose of Disclosure

☐ Coordination of care ☐ Family member access to treatment ☐ School/college

☐ Consult/second opinion ☐ FMLA/Disability ☐ Transfer of care

☐ Insurance application (e.g. long-term care) ☐ Legal (specify): _____

☐ Other: _____

Print name of Parent(s)/Legal Guardian(s): _____

Signature of Parent(s)/Legal
Guardian(s): _____

Date: ____ / ____ / ____