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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH AND CONFIDENTIAL INFORMATION

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

I _____ authorize **Dr. Stephen Sprinkle** to exchange the following protected health or other confidential information *(initial where applicable):*

____ ***Acknowledge referral and confirm participation in treatment***

____ ***Treatment summary, plan, diagnosis, and recommendations***

____ ***Full treatment record***

____ ***Other:*** _____

_____

with _____

_____

for the purpose of coordinating support and treatment. I understand that this authorization is voluntary and can be revoked at any time by contacting Dr. Sprinkle. If I don't revoke the authorization beforehand, the authorization will remain in effect until *(initial where applicable)*:

_____ ***one year from now*** OR _____ ***specify end date:*** _____***.***

_____ _____
Signature *Date*