

SHAUNA NORTON, APRN, PLLC
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Phone: (801) 748-1477
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CONSENT TO RELEASE INFORMATION

Client Name: _____
Date of Birth _____ Social Security # _____

I, _____, hereby authorize Shauna Norton, APRN, to
release and to receive information to/from: Name _____
Phone/Fax _____

- The purpose of which is:
- coordination of services
 - consultation
 - provision of necessary documents/reports
 - personal convenience

- Information to be received/released includes:
- assessment and diagnosis
 - treatment summary and recommendations
 - medical records and lab reports
 - other _____.

This Authorization, made pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPPA) and its accompanying rules and regulations, authorizes you to disclose any information and records regarding the above-identified individual. This includes, but is not limited to, your medical/mental health findings as identified specifically above. Disclosure of this information is necessary and relevant to his/her treatment. Federal regulations prohibit further disclosure without specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. A general authorization for release of medical or other information is not sufficient for this purpose.

This release shall remain in effect until 90 days after discharge from treatment.

If I am currently receiving treatment for evaluation services from Shauna Norton, APRN, I understand that this consent will remain valid for 90 days after discharge from treatment unless I express written revocation at an earlier date.

I have read the above, and understand it, and hereby voluntarily give my informed consent to the above mentioned disclosure. I understand that I may revoke this consent in writing at any time.

Client Signature	Date
Parent/Legal Guardian Signature (if client is a minor)	Date
Witness	Date