Whole Life Psychiatry

Kim D. Tubbs, PMHNP, PA, Inc.

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION/MEDICAL RECORDS

Patient name: _____ Date of Birth: _____

I hereby authorize Kim Tubbs, PMHNP to release/obtain my medical records and any personal health information concerning me to:

Recipient's name & address:

_____

_____

Phone: _____

By signing below, I give Kim Tubbs, PMHNP consent to release/obtain my medical records/personal health information without any restrictions to/from the above recipient. I understand this authorization is voluntary and made at my discretion. I may cancel/revoke this authorization at any time by giving written notice.

_____
Printed name of parent/guardian

_____
Signature of patient or parent/guardian

Date: ___/___/___