# Authorization to Release Medical Information to Insurance Company

Patient Name: ______________________________ Phone Number: ______________________________

Address: ______________________________________________________________________________

Social Security #: ______________________________ Date of Birth: ______________________________

This will authorize the Provider in the FROM section below to release and/or exchange medical information on the above named patient to the Insurance Company in the TO section below:

| FROM: | **Swarthout & Associates, LLC**<br>**David Swarthout, PsyD**<br>**1409 Willow Street, Suite # 100**<br>**Minneapolis, MN 55403** |
|---|---|
| TO: | ______________________________<br>______________________________<br>______________________________ |

The following information is to be released (check appropriate boxes):

__ Discharge Summary
__ Counselor's Discharge Summary
__ History & Physical Exam
__ Consultation Reports
__ Phone Consultation
__ Operative Reports
__ Pathology Reports
__ X-ray Reports
__ Lab Reports
__ EKG/EEG Reports
__ Emergency Dept Reports
__ Psychological Testing
__ Medication List
**X** Other reports( specify): **Diagnostic Information, /Treatment Plan for further authorizations**

For the following dates of treatment or condition: ______________________________

I am requesting this information for use by:

__ Health Care Providers
**X** Insurance Company
__ Personal
__ Attorney
__ Other (please specify): ______________________________

- **All records pertaining to psychiatric/mental health, chemical dependency and or HIV/AIDS related illness/testing will be released unless otherwise indicated by a check mark here: ____**
- I understand that I may revoke this consent at any time, and that the consent will automatically expire one year from the date of my signature.
- I understand that there may be a retrieval and/or copy charge associated with the release.
- I understand that once information is released pursuant to this authorization, Swarthout & Associates cannot prevent the re-disclosure of that information to any third party

**X**
______________________________ ______________________________
Signature of Patient Date

______________________________ ______________________________
Signature of Authorized Person – (relationship) Date