Regan Haight, APRN
Psychiatric/Mental Health Nurse Practitioner
12569 South 2700 West, Suite 202A, Riverton UT 84065
Phone: 801-701-1006 Fax: 801-701-1009
Email: reganhaight@gmail.com

Authorization to Release Information of:
Client's Name: _____Date of Birth:_____
Address: _____Phone#:_____
Social Security Number:_____

I hereby authorize Regan Haight to (check one):
_____ obtain from the following
_____ release to the following
Name:_____
Address:_____
Phone: _____ Fax:_____

The following documents/information from the records pertaining to services received
Date of Service:
The documents to be released are described or listed as:
____Discharge Summary ____Progress Notes
____Psychological Evaluation ____Labs
____Consultation Reports ____Other:_____

I understand that my authorization will remain effective from the date of my signature until_____, and that the information will be handled confidentially in compliance with all applicable federal laws. I understand that I may revoke this consent at any time by written, dated communication, except to the extent that action has been taken in reliance on it.

TO THE PARTY RECEIVING THIS INFORMATION: This information has been disclosed to you from records whose confidentiality may be protected by federal law. If so, federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without specific written consent of the person whom it pertains, or as otherwise permitted by such regulations. **A general authorization for the release of medical or other information is not sufficient for this purpose.**

I have read and understand the nature of this release.

_____ _____
Signature of Consumer/Consumer's Designated Representative Date

_____ _____
Witness Date