Peak Performance
Psychiatry & Counseling

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RELEASE OF INFORMATION

Patient Name_____

Date of Birth _____

Today's Date_____

This signed form authorizes Peak Performance Psychiatry & Counseling, PLLC to disclose and/or obtain my protected health information from the individual or organization listed below for the purposes that are checked. This consent is valid for 180 days or for the time period listed here: _____ (leave blank if 180 days is acceptable.) I understand that I may revoke this consent at any time.

The following healthcare entity is to release my medical records to Peak Performance Psychiatry & Counseling, PLLC :

And/or Peak Performance Psychiatry & Counseling, PLLC can release my documents to:

Check all that apply:

☐ Whatever information is necessary to coordinate my care

☐ Clinical records and reports ☐ Treatment plans

Patient or legal guardian_____

Witness_____