SEASONS PSYCHIATRIC CLINIC
Dr. Janet Somlyay
311 South 2nd Street, Laramie, Wyoming 82070
Phone: (307) 755-6463 | Fax: (307) 755-6460 |
seasonsclinic.org

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: Date of Birth:

I request and authorize _____
to release/receive healthcare information of the patient named above to/from:

Dr. Somlyay, DNP, PMHNP **(at above address)**

This request and authorization applies to:

○ Healthcare information relating to the following treatment, condition, or dates

○ All healthcare information ◉ Other Therapy, Treatment, Assessment, & Plan

○ Yes ○ No Continuity of care

◉ Yes ○ No I authorize the release of any records regarding drug, alcohol, or **mental health** treatment to the person(s) listed above.

I hereby consent to the release of the specified information relating to diagnosis, testing or treatment to the person or entity named above. I understand that such information cannot be released without my informed consent. I acknowledge I have fully reviewed and understand the contents of this authorization form. My signature below indicates that I hereby agree to and authorize the release of patient information to the above-named person or organization. You have the right to revoke or cancel this authorization, in writing, at any time. I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility for benefits).

Patient Signature: _____ Date: _____

Clinician's Signature: _____ Date: _____

THIS AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED.