NORTHLAND PSYCHIATRIC SPECIALISTS, LLC

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AUTHORIZATION TO **RECEIVE** CONFIDENTIAL HEALTHCARE INFORMATION

Patient Name: ____Date of Birth: ________________________

Also known as: _______________________________________Phone #: ____________________________

Social Security #: ____

I authorize Northland Psychiatric Specialists, LLC to receive confidential information regarding my treatment from:

Name: ____

Address: ____

City: ____State: ___________Zip Code: _____________

This information includes but is not limited to appointment information, billing information and medication information.

I understand that by signing this form I am allowing Northland Psychiatric Specialists, L.L.C. to receive and review confidential health information. I understand that this consent is voluntary and is subject to revocation at any time, except after the information has already been received and may only be revoked by signature.

Patient Signature: ____Date: ____________________