Christie Tanner, PsyD, LLC
4606 Commerce Valley Road, Suite 211
Eau Claire, WI 54701

Authorization to Obtain and/or Release Protected Health Information

Client Name		Date of Birth
Legal Guardian (if minor)		
Street Address		
City	State	Zip Code

I authorize Christie Tanner, PsyD, LP, 4606 Commerce Valley Road, Suite 211
Telephone (715) 828-1611 Fax: (715) 833-2131 to:

☐ Obtain my health records/information from: ☐ ☐ Release my health records/information to:

Contact Name		
Agency Name		
Street Address		
City	State	Zip Code
Phone Number	Fax Number	

The health records/information to be released are limited to:

☐ Initial Diagnostic Assessment
☐ Session Notes
☐ All
☐ First two and last two
☐ Psychological Testing
☐ Discharge Summary / Case Closing
☐ Initial Psychiatric Evaluation
☐ Psychiatric Case Notes
☐ All
☐ First two and last two
☐ School Records
☐ Probation Records, Court Orders
☐ ☐ Hospital Admission Records
☐ All Medical Records
☐ ☐ Phone Consultation
☐ Other _____
☐ ☐ Other _____
☐ ☐ Other _____

For the time period:_____

For the purpose of:

☐ Continuing Care
☐ Coordination of Services
☐ ☐ Determining Eligibility for Benefits
☐ ☐ Other_____

I understand that I may revoke this authorization at any time with written notification, but that the revocation will not have any effect on the information released prior to such notification. I also understand that this authorization will automatically expire one year from the date of my signature unless I revoke it earlier. I further understand that Christie Tanner, PsyD, LP, will not refuse or restrict my treatment if I choose not to sign this authorization. A photocopy and/or fax of this authorization will be treated in the same manner as an original.

If you are the client's legal representative, please attach a copy of the document that gives you the authority to act as the legal representative. You are entitled to a copy of this document.

Client Signature	(Please Print)	Date
Legal Guardian Signature	(Please Print)	Date
Witnessed by - Signature		Date