

**Dr. Nancy A. Logan, Ph.D.**

**RECORDS RELEASE**

Frequently it is helpful for me to be able to communicate with other health care providers who also tend to your care. This would be done in order to coordinate your treatment and/or communicate about how you are doing, etc.

This exchange of information would happen ONLY with your consent.

TO: Nancy A. Logan, Ph.D.

**EITHER:** I hereby authorize you (health care provider) to \_\_\_\_ provide and/or \_\_\_\_ receive any pertinent information regarding my care. (Please check the desired box(es) above).

Physician or Health care provider name: \_\_\_\_\_

Physician or health care provider address: \_\_\_\_\_

Physician or health care provider phone: \_\_\_\_\_

**OR**

\_\_\_\_ I hereby **do not** authorize you to provide or receive any pertinent information regarding my care.

This exchange of information may include diagnosis, treatment plan, prognosis, or other information perceived as important for us to improve our ability to help you during the period from

(date) \_\_\_\_\_ to \_\_\_\_\_.

You may change this release at any time by written notification.

Patient's name: \_\_\_\_\_ DOB: \_\_\_\_\_

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Signature, print name and date