Professional Monitoring Inc

121 10th St NW, Rochester, MN 55901-6843
205-639-7546 (Office) shannonskipper@professionalmonitoringl.com

Authorization and Consent to Release Information

Name _____ Date of Birth _____

Address _____ City/State/Zip _____

I hereby authorize and request that DR SKIPPER release the following information which may be available:

Describe records to be released:

_____
_____
_____
_____
_____

Types of Records to be Released:

( ) Assessment/evaluation Findings
( ) Discharge Summary
( ) Psychiatric/Psychological Records

( ) Assessment/evaluation Findings
( ) Discharge Summary
( ) Psychiatric/Psychological Records

( ) Monitoring Agreement
( ) Urine Drug Screen Reports
( ) Other (Please specify) _____
_____

To:

Name _____ Address _____

City/State/Zip _____ Phone _____ FAX _____

I hereby authorize the release of the above information and release and hold harmless Professional Monitoring Inc and its agents or employees from any and all claims for damages arising out of or related to the release of the information specified above.

1. **I understand that I have the right to withdraw this authorization at any time. I authorize a photocopy of this release to be used in lieu of an original signed document.**
2. **The information contained herein is confidential and is being provided in response to this written authorization. Further disclosure by the receiving party is prohibited.**

Date: _____ _____
Signature of Consenting Party

Witness Signature: _____