11422 Miracle Hills Dr. STE 401 Omaha, NE 68154 | Phone 531.203.5928 | Fax 531.227.7732

Release of Information

I, Robert Lloyd Mitchell________, hereby authorize Resilient Psychiatry to:

________ Release Information To (indicated below)

___X____ Obtain Information From (indicated below) CONTINUATION OF CARE

________ Collaborate/Exchange Care Planning With (indicated below)

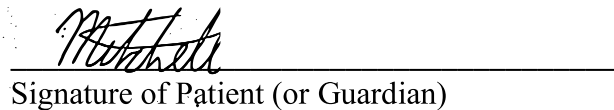
Business or Individual's Name: Clovis Surgery Center

Address: 1820 W 21st St, Clovis, NM 88101

Phone: 575.762.2207 Fax: 575.762.7108

This authorization is valid for one year from the date below or ___________, whichever is earlier. I may cancel this authorization by signing, dating, and writing "CANCEL" on this original form or by sending a written, signed and dated request to the provider above indicating my desire to cancel. I understand that once my information has been released, the recipient might re-disclose it, my provider has no control over it and privacy laws may no longer protect it. The purpose of this authorization is to improve the quality of my mental health evaluation or treatment.

Robert Lloyd Mitchell
Printed Patient Name


Signature of Patient (or Guardian)

02.03.1978
Patient's Date of Birth

07.21.2024
Today's Date

N/A
Signature of Witness