

AUTHORIZATION TO RELEASE PATIENT INFORMATION

Please complete this form. Items not checked or blanks unfilled are assumed to be non-applicable or specifically not authorized for release. This release is not valid without an authorized signature and date or if it has expired.

	Last	First	MI	Previou	is Name, if any
DOB:	SS#	F	hone:		
				Home	Cell
Resident Address:	 Street		ity	State	Zip Code
I authorize			•		·
Address:					
	treet	Ci	_	State	Zip Code
Phone:	Fax:		Ema	il:	
Covering the periods o	f healthcare from (da	ate)		to (date)	
For the purpose of:					
		(If requested b	y the patien	it, state "At the re	quest of the Individual")
Method of disclosure:	Mail Verbal	Pick Up	Fax	Email	
The following information	may be released: (ex.	clinical summari	es, lab repo	rts, nurses' notes,	or all medical records)
I give specific authorization	-		s documents	that contain referer	nce to:
	results and documentation I alcohol abuse treatment	ŭ			
· ·	ic/Mental Health treatmer				
		it records			
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