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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

PATIENT'S NAME: _____ DATE OF BIRTH: _____

PREVIOUS NAME (IF APPLICABLE): _____

I REQUEST AND AUTHORIZE _____TO

RELEASE HEALTHCARE INFORMATION OF THE PATIENT NAMED ABOVE TO:

NAME: _____

ADDRESS: _____

CITY: _____STATE: _____ ZIP: _____

PHONE: _____FAX: _____

THIS REQUEST AND AUTHORIZATION APPLIES TO:

___HEALTHCARE INFORMATION RELATING TO THE FOLLOWING TREATMENT, CONDITION, OR DATES:

_____

___ALL HEALTHCARE INFORMATION

___OTHER: _____

___YES ___NO I AUTHORIZE THE RELEASE OF ANY RECORDS REGARDING DRUG, ALCOHOL, OR MENTAL HEALTH TREATMENT TO THE PERSON(S) LISTED ABOVE.

PATIENT OR GUARDIAN SIGNATURE: _____

DATE SIGNED: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED