# AUTHORIZATION TO RELEASE INFORMATION

Please Print Clearly
Patient Name:

_____

Last First Middle Initial

Address_____

Street City State Zip Code

Phone: (____)_____ Date of Birth_____ Social Security#_____

I authorize:
Name of Doctor,Hospital, etc._____

Address: _____

City/State/Zip
Code:_____Phone#_____Fax#_____

To Release Medical Documents to:
Name of Doctor, Hospital,etc._____

Address:_____

City/State/Zip Code:_____

For purpose of review/examination and further authorize you to provide such copies (thereof as may be requested). The foregoing is subject to such limitation as indicated below:

- ❑ Entire Record
- ❑ Specific Information
- ❑ Old Records for Previous Physicians/Facilities

I give special permission to release any information regarding (initial on line(s) below that you grant us permission to release the information to the above)

_____ Substance Abuse _____Psychiatric/Mental Health Information _____HIV Information

This authorization will automatically expire one year from the date signed. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance thereon.

Reason for Request_____

Signed: _____ Date: _____
(IF NOT PATIENT, STATE RELATIONSHIP)

Witness: _____ Date:_____

**FOR OFFICE USE ONLY**

Date Received: _____ Completed by: _____
(Employee Name)

Fee paid if applicable: $_____ Amount Due/Billed: _____