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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name:		Date of Birth:	
Previous Name:		SSN #:	
Patient Phone#			
I request and authorize:			

Check Box: **RELEASE TO (x) OBTAIN FROM ( ) COMMUNICATE WITH ( )**

ADDRESSS					
CITY		State		Zip Code:	

Fax#	Phone#
☐ THIS REQUEST AND AUTHORIZATION APPLIES TO THE FOLLOWING DOCUMENTS AND HEALTHCARE INFORMATION RELATED TO THE FOLLOWING TREATMENT DATES (IF APPLICABLE)	

( ) PSYCHIATRIC EVALUATION **( ) PSYCHOLOGICAL EVALUATION**
( ) CONSULTATION **( ) PROGRESS NOTES**
( ) TREATMENT PLAN **( ) LAB REPORTS**

☐ Yes ☐ No	I authorize the above named person/member(s) of their staff to furnish information, including photostatic copies of my medical records, concerning my treatment, to the above organization or its agents, and I further agree to indemnify and hold harmless its staff from all liability that may arise from the release of the information herein requested. Any information obtained from this authorized release should not be released to any other person(s) unless I specifically authorize. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these records to anyone.
☐ Yes ☐ No	I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.
☐ Yes ☐ No	I understand that I may revoke this consent in writing at any time, except to the extent that action has been taken in reliance thereon, and that this authorization is valid for a period of 180 days from the date of my signature.

Patient Signature:		Date Signed:	

THIS AUTHORIZATION EXPIRES 180 DAYS AFTER IT IS SIGNED.