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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: Date of Birth: [DOB]

Previous Name: Social Security #:

I request and authorize [Authorized individual] to release healthcare information of the patient named above to:

This request and authorization applies to:

○ Healthcare information relating to the following treatment, condition, or dates

○ All healthcare information ○ Other

[Additional information]

○ Yes ○ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date signed: [Date]

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED UNLESS OTHERWISE STATED