



AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Other Name: _____ Social Security #: _____

I request and authorize _____ to
release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This request and authorization applies to:

Medical records relating to the following treatment, condition, or dates: _____

All medical records

Other: _____

Yes No I consent to the disclosure of evaluation or treatment of reportable communicable diseases including sexually transmitted diseases and HIV (AIDS).

Yes No I consent to the disclosure of substance/alcohol abuse evaluation/treatment.

Patient Signature: _____ Date Signed: _____

Address: _____ Phone: _____