AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____Date of Birth: _____

Guarantor Name: _____Relation: _____

Patient contact # _____Patient Email _____

I authorize the request for release of information FROM:

Entity Name: _____Provider Name:_____

Location: _____Department: _____

Phone # _____Fax # _____

I authorize the requested info to be released TO:

Entity Name: _____Provider Name: _____

Location: _____Department: _____

Phone # _____Fax # _____

Authorize both entities to communicate by: Yes/No Phone _____ Email _____

This request authorizes release of the following records:

Mental Health records related but not limited to the following:
- Developmental screenings and/or clinical documentation of developmental delay
- Clinical documentation of diagnoses
- Evaluation/and or assessment reports
- Treatment plan and chart notes

Other:

I also authorize for the release of drug and/or alcohol treatment records. **Initials** _____

Name Printed: _____Patient signature: _____Date_____

Guarantor Name_____ Guarantor Relation_____

Guarantor signature:_____ Date signed: _____

I understand this authorization is will expire one year from the date signed or otherwise stated below.

☐ expire after 90 days ☐ expire after 6 months client intials _____

NOTICE TO WHOM THIS INFORMATION IS GIVEN: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations prohibit you from making further disclosure of this information without the specific written consent of the person to whom it pertains.