Authorization for Release/Disclosure of Protected Health Information

Please complete the following information:

Patient Name: _____

Address: _____

_____

Phone: _____ DOB:_____/_____/_____

I HEREBY AUTHORIZE *(name of person or facility that has information)*:

_____

TO RELEASE TO *(name of person or facility to receive information)*:

_____

The following Information:

☐ All records ☐ History ☐ Progress Notes ☐ Treatment Plan

Type of Disclosure:

☐ Verbal Information/ Communication ☐ Copies of Records

☐ Other (describe specifically) _____

The purpose/reason for the release of this information is:

_____

This authorization shall expire no later than: ___/___/___ or one year from the date of signature if no expiration date is given.

Signature: _____ Date:_____

Signature of Guardian/Parent: _____

Printed name of Guardian/Parent: _____