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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Social Security #: _____ Date(s) of Service Requested: _____

Information Requested: _____

Purpose of Disclosure: _____

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

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

I understand that this information may include reference to psychiatric care, sexual assault, alcohol abuse and/or drug abuse and results of tests for all infectious diseases including AIDS/HIV.
I understand that I have the right to revoke this authorization at any time by notifying the office in writing.
I understand that revocation will not apply to information that has already been released in response to this authorization.
I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
I understand that authorizing the disclosure of this private health information is voluntary and that I can refuse to sign this authorization.
I understand that I may inspect or obtain a copy of the information to be used or disclosed.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Printed Name of Patient or Legal Representative Relationship to Patient, if signed Legal Guardian/Representative