

**AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Previous Name: \_\_\_\_\_

I request and authorize \_\_\_\_\_

To release healthcare information of the patient named above to:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

This request and authorization apply to:

- Yes  No I authorize the release of any records regarding education, medical, psychological, psychiatric, social, psychometric (testing) drug, billing information, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

THIS AUTHORIZATION EXPIRES SIX MONTHS AFTER IT IS SIGNED