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AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____
Patient Name PRINT

_____
Social Security Number

_____
Date of Birth

Authorize release of medical records

From:	To:
_____	_____
_____	_____
_____	_____
Fax # _____	Fax # _____

Dates of Treatment: _____
Records to include:
_____ Initial Evaluation
_____ All Radiology (MRI, CT scan, X-ray, etc)
_____ Labs
_____ Entire Medical Record
_____ Other _____

GENERAL AUTHORIZATION: I understand and acknowledge that this general authorization allows the health care facility to release all or part of the records indicated above for the purpose stated. I understand that, on occasion, information may be released by telephone or fax. **This consent is valid for 90-days, unless revoked by me in writing before the release of the above designated information.**

I have read this form, or had it read to me and I understand it. I was given an opportunity to ask questions, any question asked was answered to my satisfaction. My signature below indicates my voluntary authorization for both general and special release of information.

_____	_____	_____
Signature of Patient	*Date*	*Name/Relationship to patient, if patient unable to sign*