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RELEASE OF INFORMATION

PATIENT NAME: _____ **DOB:** _____

INFORMATION TO BE RELEASED:

FROM/TO: _____
Name/Agency

_____
Address

FROM/TO: _____
Name/Agency

_____
Address

PURPOSE FOR RELEASE:

- ☐ CONTINUED CARE BY RECEIVING FACILITY/DOCTOR/THERAPIST
- ☐ CLAIMS SETTLEMENT WITH INSURANCECOMPANY
- ☐ AID BY THE ABOVE NAMED AGENCY/PROFESSIONAL
- ☐ LEGAL PROCEEDINGS OR ADVICE
- ☐ OTHER _____

TYPE OF INFORMATION TO BE RELEASED:

_____

_____

_____

This information is effective immediately and is subject to revocation at any time, except to the extent that action has already been taken. Otherwise, this authorization expires one year from the date of signing.

I realize that this is a required consent and that I voluntarily and knowingly sign this authorization before any records can be released, and that I may refuse to sign; but, in that event, the records cannot and will not be released.

I further release the record holding entity from any liability arising from the release of information to the person(s) or agency designed above.

_____ _____

PATIENT **DATE** **WITNESS** **DATE**

_____

GUARDIAN (If applicable) **DATE**