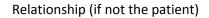


Patient Date of Birth:/_	/ Patient SS	5N:	
I,	, hereby	consent to the release of my medical record	S.
(Please print patient nam	e)	,	
I understand my records will b	e released TO / FROM:		
Person/Entity			
A 1 1			
Phone Number	Fax Numb	per	
Records that will be released a	are: (please check all that a	pply)	
		ons, images, etc. Dates:	
Notes for all dates of ser			
Billing information			
Other			
O Continuity of care/othe	er provider	O Other(specify)	
<ul> <li>Request of the patient</li> </ul>			<del></del>
<ul> <li>Attorney/client relation</li> </ul>	nship		
O Insurance			
understand that this authorization	n will remain in force until revo	· ·	sclosed. I
I acknowledge that the records to	be released MAY include mat	and Alcohol, and Mental Health Records: Perial that is protected by Federal Regulation 42 Cl Pease of all information. Check here to suppress dis	
•		release of said medical records and/or billing info	
Unless Revoked, this authoriza	ation expires in 180 days or	r on this Date:	
Signature of Patient (or other r	esponsible person)	 Date	
3	, , , , , , ,		

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