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Authorization For Release Of Information/Sensitive Medical Records

I, _____
Name
Of, _____
Address City, State Zip
Social Security Number_____, Date Of Birth_____
Hereby Authorize_____ To Disclose To_____
The Following Specific Information: _____
_____
_____
For The Purpose Of Coordinating Medical And Psychiatric Evaluation And Treatment And _____
_____
I have been informed of the type of information being released and that treatment is not contingent upon my decision concerning the signing of the release. I understand that I may revoke this consent at anytime except to the extent that action has been already taken. This consent automatically expires in one year unless specifically stated herein.

Signature_____, Date_____
Patient
_____, Date_____
Parent/Legal Guardian
_____, Date_____
Witness