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**Release from:**

Office name: ______________________________

Phone: ______________________ Fax: ______________________

Address: ______________________________

Email: ______________________________

**Release to:**

Office name: ______________________________

Phone: ______________________ Fax: ______________________

Address: ______________________________

Email: ______________________________

**Patient Information:**

Patient name: ______________________ DOB: ______________

Address: ______________________________

Phone: ______________________

**Client Rights:**

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment, or enrollment). I may revoke this authorization at any time. I understand that one the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws

**Patient Signature:** ______________________ **Date:** ______________

**Print Name:** ______________________