

Patient Name:		1							
Patient Telephone:  Person or Organization Authorized to Release the Protected Health Information:  Address:  Phone Number:  Fax Number:		Patient Date of Birth:  Patient SS Number (optional):  Person or Organization Authorized to Obtain the Protected Health Information:  Address:  Phone Number:  Fax Number:							
						Records to be released sho	uld include: (INIT)	(AL EACH)	
					Description	Date(s) of Service	Des	cription	Date(s) of Service
					Progress Notes			ation History	2210(3) 01 001 110
					Laboratory/Pathology Results		☐ Billing Re		
					Diagnostic Imaging			agement records	
Consultation Reports		Other:	-						
Medication Lists		1							
I hereby request and authorize the above named above to release/exchange informations and that the information to the state of the stat									
I hereby request and authorize the above named above to release/exchange information to be repsychiatric impairments, and HIV/AID system. IUNDERSTAND THAT INFORMATHAT AND INFORMATHAT INFORMATHAT AND THAT INFORMATHAT AND THAT INFORMATHAT AND INFORMATHAT AND INFORMATHAT AND INFORMATHAT AND INFORMATHAT AND INFORMATHAT INFORMATHAT AND INFORMATHAT INFORMATHATION INF	leased/exchanged may include S. This information may be tra ATION TRANSMITTED BY FAX I of reach its intended destination eral and state law. I acknowled facility and its employees from the opp or fax of this authorization and under Federal regulations go lisclosed without my written cut at any time by dating and sign. I understand my refusal to	the agency, organization in the agency, organization in formation about surprised electronically in and could reach any dige that my signature in any legal responsibing it is as effective as the overning Confidential consent unless otherwisping the revocation begive authorization in the confidence of the confidence o	on or individual name ibstance abuse, psychy through fax or the COREMAIN CONFIDING type of destination. On this form is volubled as a result of any original.  ity of Alcohol and E se provided for in the clow, except to the cono way jeopardizes	ed on this request. I hological or Provide database ENTIAL. I understand I understand my right ntary and valid. y information being  Orug Use Patient the regulations. I also extent that action my right to obtain					
I hereby request and authorize the above named above to release/exchange information to be repsychiatric impairments, and HIV/AID system. IINDERSTAND THAT INFORMATHAT AND THAT INFORMATHAT INFORMATHATION INFO	leased/exchanged may include S. This information may be traction may be traction to track the straction of t	the agency, organization in the agency, organization in formation about surprised electronically in and could reach any dige that my signature in any legal responsibing it is as effective as the overning Confidential consent unless otherwisping the revocation begive authorization in the confidence of the confidence o	in or individual name ibstance abuse, psycy through fax or the CO REMAIN CONFIDING type of destination. On this form is volubled as a result of any original.  ity of Alcohol and I see provided for in the clow, except to the cono way jeopardizes information as star	ed on this request. I hological or Provide database ENTIAL. I understand I understand my right ntary and valid. y information being  Orug Use Patient the regulations. I also extent that action my right to obtain					
I hereby request and authorize the above named above to release/exchange informunderstand that the information to be repsychiatric impairments, and HIV/AID system. IUNDERSTAND THAT INFORMATHAT any information transmitted may not to confidentiality is protected under fede Signing this authorization, releases this transmitted by fax. I understand that a c I understand that my records are protected Records, 42 CFR Part 2, and cannot be dunderstand that I may revoke this consent based on this authorization has been taked present or future services.  I have read the above ant's Signature:	leased/exchanged may include S. This information may be tra ATION TRANSMITTED BY FAX I at reach its intended destination eral and state law. I acknowled facility and its employees from opy or fax of this authorization at under Federal regulations go lisclosed without my written count at any time by dating and sign. I understand my refusal to and authorize the disclosure	the agency, organization in the agency, organization in formation about surprised electronically in and could reach any dige that my signature in any legal responsibing it is as effective as the overning Confidential consent unless otherwisping the revocation begive authorization in the confidence of the confidence o	in or individual name in the content of the content	ed on this request. I hological or Provide database ENTIAL. I understand I understand my right ntary and valid. y information being  Orug Use Patient the regulations. I also extent that action my right to obtain					
I hereby request and authorize the above named above to release/exchange information to be repsychiatric impairments, and HIV/AID system. IUNDERSTAND THAT INFORMATHAT AND INFORMATHAT AND INFORMATHAT AND THAT INFORMATHAT AND THAT INFORMATHAT AND INFORMATHAT INFORMATHAT AND INFORMATHAT AND INFORMATHAT AND INFORMATHAT INFORMATHAT AND INFORMATHAT INFORMATHATION INF	leased/exchanged may include S. This information may be tra ATION TRANSMITTED BY FAX I at reach its intended destination eral and state law. I acknowled facility and its employees from opy or fax of this authorization at under Federal regulations go lisclosed without my written count at any time by dating and sign. I understand my refusal to and authorize the disclosure	the agency, organization in the agency, organization in formation about surprised electronically in and could reach any dige that my signature in any legal responsibing it is as effective as the overning Confidential consent unless otherwisping the revocation begive authorization in the confidence of the confidence o	in or individual name ibstance abuse, psycy through fax or the CO REMAIN CONFIDING type of destination. On this form is volubled as a result of any original.  ity of Alcohol and I see provided for in the clow, except to the cono way jeopardizes information as star	ed on this request. I hological or Provide database ENTIAL. I understand I understand my right ntary and valid. y information being  Orug Use Patient the regulations. I also extent that action my right to obtain					
I hereby request and authorize the above named above to release/exchange informunderstand that the information to be repsychiatric impairments, and HIV/AID system. IUNDERSTAND THAT INFORMATHAT any information transmitted may not to confidentiality is protected under fede Signing this authorization, releases this transmitted by fax. I understand that a c I understand that my records are protected Records, 42 CFR Part 2, and cannot be dunderstand that I may revoke this consent based on this authorization has been taked present or future services.  I have read the above ant's Signature:	leased/exchanged may include S. This information may be tra ATION TRANSMITTED BY FAX I at reach its intended destination eral and state law. I acknowled facility and its employees from opy or fax of this authorization at under Federal regulations go lisclosed without my written count at any time by dating and sign. I understand my refusal to and authorize the disclosure	the agency, organization in the agency, organization in formation about surprised electronically in and could reach any dige that my signature in any legal responsibing it is as effective as the overning Confidential consent unless otherwisping the revocation begive authorization in the confidence of the confidence o	in or individual name of individual name of individual name of the stance abuse, psyce by through fax or the stock of the standard of the stan	ed on this request. I hological or Provide database ENTIAL. I understand I understand my right ntary and valid. y information being  Orug Use Patient the regulations. I also extent that action my right to obtain					
I hereby request and authorize the above named above to release/exchange information to be repsychiatric impairments, and HIV/AID system. IUNDERSTAND THAT INFORMATHAT AND INFORMATHAT INFORMATHAT AND INFORMATHAT INFORMATHAT AND INFORMATHAT INFORMATHAT AND INFORMATHAT AND INFORMATHAT INFORMATHAT AND INFORMATHAT INFORMATHATION INFORMATHAT INFORMATHATION INFORMATHA	leased/exchanged may include S. This information may be tra ATION TRANSMITTED BY FAX I of reach its intended destination eral and state law. I acknowled facility and its employees from the opp or fax of this authorization and under Federal regulations go disclosed without my written count at any time by dating and sign. I understand my refusal to and authorize the disclosure	the agency, organization in incident and could reach any legal responsibilities as effective as the coverning Confidential consent unless otherwing the revocation begive authorization in its assets of protected health	in or individual name ibstance abuse, psycy by through fax or the COREMAIN CONFIDING type of destination. On this form is volulity as a result of any original.  ity of Alcohol and I see provided for in the elow, except to the elow, except to the one way jeopardizes  information as start Date:  Date:  Date:	ed on this request. I hological or Provide database ENTIAL. I understand I understand my right ntary and valid. y information being  Orug Use Patient the regulations. I also extent that action my right to obtain					
I hereby request and authorize the above named above to release/exchange information to be repsychiatric impairments, and HIV/AID system. IUNDERSTAND THAT INFORMATHAT AND INFORMATHAT INFORMATHAT AND INFORMATHAT INFORMATHAT AND INFORMATHAT INFORMATHAT AND INFORMATHAT AND INFORMATHAT INFORMATHAT AND INFORMATHAT INFORMATHATION INFORMATHAT INFORMATHATION INFORMATHA	leased/exchanged may include S. This information may be trace that information may be traced its intended destination and state law. I acknowled facility and its employees from the opy or fax of this authorization and under Federal regulations go its closed without my written count at any time by dating and sign. I understand my refusal to and authorize the disclosure is and authorize the disclosure is a significant will expire in 90 days unication will expi	the agency, organization in the information about sunsmitted electronically and could reach any dige that my signature in any legal responsibilities as effective as the overning Confidential consent unless otherwitening the revocation begive authorization in the of protected health	in or individual name ibstance abuse, psycy by through fax or the COREMAIN CONFIDING type of destination. On this form is volulity as a result of any original.  ity of Alcohol and I see provided for in the elow, except to the elow, except to the one way jeopardizes  information as start Date:  Date:  Date:	ed on this request. I hological or Provide database ENTIAL. I understand I understand my right ntary and valid. y information being  Orug Use Patient the regulations. I also extent that action my right to obtain					
I hereby request and authorize the above named above to release/exchange information to be repsychiatric impairments, and HIV/AID system. IUNDERSTAND THAT INFORMATHAT AND INFORMATHAT INFORMATHAT AND THAT INFORMATHAT AND THAT INFORMATHAT AND INFORMATHAT INFORMATHATION INFORMATHA	leased/exchanged may include S. This information may be tra ATION TRANSMITTED BY FAX I of reach its intended destination eral and state law. I acknowled facility and its employees from opy or fax of this authorization ed under Federal regulations go lisclosed without my written cut at any time by dating and sign. I understand my refusal to and authorize the disclosure	the agency, organization in incomparison about surprised electronically in and could reach any dige that my signature in any legal responsibilities as effective as the coverning Confidential consent unless otherwite in the protected health in the coverning the revocation begive authorization in the confidence of protected health in the consent unless otherwite in the confidence of protected health in the consent effective:	in or individual name ibstance abuse, psycy by through fax or the COREMAIN CONFIDING type of destination. On this form is volulity as a result of any original.  ity of Alcohol and I see provided for in the elow, except to the elow, except to the one way jeopardizes  information as start Date:  Date:  Date:	ed on this request. I hological or Provide database ENTIAL. I understand I understand my right ntary and valid. y information being  Orug Use Patient the regulations. I also extent that action my right to obtain					