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AUTHORIZATION TO RELEASE MEDICAL INFORMATION
I, ___________________________ authorize _______________________, on ___/___/_____ to obtain and release information and records pertaining to my evaluation and treatment, for purpose of providing records or information to

____

for the purposes of _________________________.

This is a single disclosure. ______This disclosure is good for 90 days. ______ This disclosure is good for one year.

Date disclosure signed ___/___/____.Date disclosure expires___/___/____. _____Check here if this authorization allows for VERBAL exchange only. _____Check here if this authorization allows for exchange of medical records.

I hereby release the above named practitioner from liability which may arise as a result of the information contained in the records released:

Signature of Client:_________________________Date:_____________
Printed name of Client:______________________Date:_____________
Signature of Guardian:______________________Date:_____________
Printed name of Guardian:___________________Date:_____________
Signature of Witness:_______________________Date:_____________
_ Printed name of Witness:____________________Date:__________ ____