Cardinal Therapy

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____

I request and authorize _____ to receive and release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This request and authorization applies to:

☐ Mental health records relating to the following treatment, condition or dates: _____

_____

☐ All mental health records

☐ Other: _____

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

Parent/ Guardian Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED.