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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____

Date of Birth: _____

Abbeyfield Clinician's Name:

I request and authorize [Authorized individual] to release healthcare information of the patient named above to / from:

Address: _____

This request and authorization applies to:

Coordination of care/treatment: I authorize the release of clinical information and records obtained in the course of my diagnosis/treatment.

Coordination/Allocation of benefits

Other:

Client Signature: _____ Date signed: _____

Authorized Person
(if under 18): _____ Date signed: _____

Printed Name: _____

Relationship to
Client: _____

This disclosure is intended for the above named person(s); any further disclosure to those not named above is violation of Federal HIPPA laws.