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CONSENT TO RELEASE AND EXCHANGE PROTECTED HEALTH AND ACCOUNT INFORMATION

| Patient's Name: | DOB: _ | | _ | |
|---|---|--|--|-------------------------------------|
| I hereby authorize and give access t | to the named individual or entity below | w (information is comin | g from this person/office): | |
| Individual/Entity Name: | | | | |
| Address: | City: | State: | Zip: | |
| Phone: | Fax: | | _ | |
| To release to and/or exchange with protected health and account inform | the named individual or entity below mation: | (information is going to | this person/office) the following | specified |
| Individual/Entity Name: | | | | |
| Address: | City: | State: | Zip: | |
| Phone: | Fax: | | _ | |
| Please check all that apply: | | | | |
| All medical records Hospital/Facility records Account/appointment info | Medication records Psychological testing reco Other (please specify): | Labora ordsSchool | tory testing results records, reports, and forms | |
| This release will include all dates | s of service unless a date range is sp | ecified:/t | 0// | |
| Continuity of care School requirement(s) | Spouse/Parent consent | Insurance Other (please spe | Disability/FMLA | |
| phone, fax, or mail. This disclosu psychological or psychiatric impor- receives or releases this informa regulations (HIPPA), the released patient or guarantor and my no l | ne protected health and account info are and/or exchange may include in airments, HIV and/or Aids, or other tion is not a health-insurance plan o d information may be re-disclosed a onger be protected by federal or sta eive health-care services, reimburse | formation regarding of physical conditions. For a health-care provint will by the recipient at law. If I refuse to s | drug, alcohol or sexual abuse, If the authorized individual or der covered by federal privacy or sender without the consen ign this form, I understand tha | entity that t of the at it will no |
| NOTE: This consent does not expalready been taken prior to revo | ire; however, it may be revoked at a cation. | nny time IN WRITING, | except to the extent that any a | ction has |
| | bove statements and I consent to the thind that there may be costs incurred | | | |
| Printed Name | Signature | //_ Date Signed | | |
| Relationship to patient: Self | Parent Legal Guardian *Documentation | | wer of Attorney* | |
| Witness Signature | | | | |