RECORDS/INFORMATION RELEASE

TO: _____
CLINICIAN'S NAME

I, _____, give permission for you to
PATIENT'S NAME OR GUARDIAN'S NAME

_____Discuss information pertaining to my diagnosis, treatment, prognosis, recommendations, as well as other data pertinent to treatment, with

_____
DOCTOR'S NAME OR FAMILY MEMBER'S NAME

_____
ADDRESS

_____

_____
PHONE NUMBER

_____Release information in my medical records pertaining to my treatment to _____
DOCTOR'S NAME OR FAMILY MEMBER'S NAME

_____
ADDRESS

_____

_____
PHONE NUMBER

I understand that I may decide to revoke this permission at any time by notifying _____ in writing of my decision.
NAME

_____ (SEAL) _____
FIRST & LAST NAME DATE

Print Name