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**PATIENT AUTHORIZATION TO DISCLOSE, RELEASE OR OBTAIN
PROTECTED HEALTH INFORMATION**

Patient's Name (*Please Print*): _____ **DOB:** _____

Patient
Signature: _____ **Date:** _____

Parent/Legal
Guardian: _____ **Date:** _____

Parent/Legal
Guardian: _____ **Date:** _____

Telephone #: _____

INFORMATION TO BE RELEASED FROM:

Physician/Clinic/
Person: _____
Address: _____
City, State, Zip: _____
Tel: _____ Fax: _____

INFORMATION TO BE RELEASED TO:

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