



Authorization for Release of Information

I hereby authorize any and all individuals listed below to request and receive any protected health information regarding my treatment, payment and/or administrative operations related to treatment and payment. I understand that the identity of authorized individuals must be verified before release of any information. (i.e. coaches, assistants, receptionist/secretary, spouse, parents (if patient is over 18), etc.) If you do not have anyone to list, please mark thru the lines below and sign at the bottom to show you addressed this form.

Authorized Individuals:

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Patient Name _____

Patient Signature _____ Date _____