CONSENT FOR RELEASE OF CONFIDENTIAL PATIENT INFORMATION

Patient Name: ____ DOB: ______________

This consent will authorize:

____

Facility/Individual Releasing Info

____

____

Mailing Address

To release the following: ( ) Entire Medical Report
( ) Specific Date/Report: __________________________________

To:

____

Facility/Individual Requesting Info

____

____

Mailing Address

For the following purpose:

____

I understand that I may revoke this consent at any time prior to the records being released. This consent will expire 45 days after signature. I understand that I have the right to examine and copy the records that are to be released, unless deemed that such disclosure is not in my best interest.

Patient Signature: ____ Date: ______________

Witness Signature: _______________________________________ Date: ______________

Parent/Guardian: ____ Date: ______________

Completed by: ____ Date: ______________

2017 W Woodland St Springfield, MO 65807 Ph: (417)889-4800 Fax: (417)889-0980 Website: advantagetherapyonline.com