

Michael Parker, LCSW
2526 Monroeville Blvd, Ste 208
Monroeville, PA 15146
412-256-8256

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Social Security# _____

I request and authorize _____ to release

healthcare information from the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

This request for authorization applies to:

Information relating to the following treatment, condition, or dates: _____

All healthcare information

Other: _____

Yes No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person listed above.

Patient Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

For clients younger than 14

Witness Signature: _____ Date: _____

THIS AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED.