

Patient Name: DOB:

Telephone Number:

I hereby authorize Allison holt and Associates to: (choose one):

- Obtain copies of records from: Disclose copies of records to: Verbal/Written Contact:

Name:

Address:

City/State/Zip:

Phone: Fax:

Information to be released (please check all that apply):

- | | | |
|---|---|--|
| <input type="checkbox"/> History and Physical | <input type="checkbox"/> Emergency Room Report | <input type="checkbox"/> AIDS/HIV Related Illness/ Testing |
| <input type="checkbox"/> Diagnostic Interview | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Laboratory Report |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Treatment Plan/Care Plan | <input type="checkbox"/> Medications |
| <input type="checkbox"/> Psychiatric Evaluation | <input type="checkbox"/> Chemical Dependency Information | <input type="checkbox"/> Other Information (Please specify below) |

Please indicate any restrictions (specify):

I am requesting this information be released for the following purposes (must circle at least one):

- Continued Care Legal Patient's Request Insurance SSDI
 Other (Please specify below)

I understand I may revoke this authorization by written request at any time to the address listed at the top of this form. This authorization will automatically expire one year from the date of my signature.

Signature of Patient/Legal Representative

Date

Print Name of Legal Representative

Legal Representative's Authority to Sign

Reason Patient is Unable to Sign (please check one): Minor Deceased Other: