



Authorization to Release Medical Information

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Date: ___/___/___ Date of Birth: ___/___/___ SSN: _____

Patient Name: _____

Address: _____ City/State/Zip: _____

I, the undersigned, do hereby grant permission for **Dr. Asher Diamond** to

obtain from or release to:

(Name of person or institution the information will be coming from)

(Address of person or institution the information will be coming from)

The following information from the patient's clinical record:

All necessary medical records

Other: _____

I understand that this information will be used for the purpose of:

Providing information to allow care to be provided to the patient

Supporting the payment of an insurance claim

Other: _____

This authorization will be valid for the period of twelve months unless otherwise specified below.

I understand that I may revoke this consent at any time by sending a written notice. I understand that any release which has been made prior to my revocation which was made in reliance upon this authorization shall not constitute a breach of my rights to confidentiality. I understand that I may review the disclosed information by contacting the above named health care provider.

Signature of Patient or Patient's Authorized Representative _____

Relationship to Patient: _____

Date: _____

Specific authorization for release of information protected by state or federal law - I specifically authorize, by writing my initials beside the category and signing below, the release of data and information relating to:

Substance abuse Mental Health AIDS/HIV

Signature of Patient _____

Date: _____