Release of Information
Authorization to Release or Obtain Health Care Information

Patient Name	
Address	
Birthdate	
Phone	

I hereby authorize Healing For All, LLC to request or release the medical information about me indicated below to the following person/intended recipient :

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- I am aware that my records may contain information related to mental health, substance abuse and sexually transmitted diseases (including test results related to HIV/AIDS), and I specifically authorize the release of such information pursuant to this Authorization.
- I understand that this authorization will expire in one (1) year, but I may revoke it at any time in writing. I understand that any such revocation will not apply to any information already released under this Authorization.

Intended Recipient:	
Address:	
Phone:	Fax:
Email Address:	
Documents Needed:	
Purpose of Release: Continued Care Collaboration Requesting Specific Records Insurance Personal Disability Other:_____________ Legal If for continued care, records are needed for doctor's appointment on: _________________________	

This Authorization allows for exchange of medical information by telephone or other direct verbal communication in lieu of written communication.

Patient Signature: ___________________________________ Date: _______________________