AUTHORIZATION TO RELEASE MEDICAL INFORMATION

☐ I hereby authorize and request:

_____

_____

_____

to release confidential professional information to **ALMA BEHAVIORAL GROUP**

☐ I hereby authorize and request **ALMA BEHAVIORAL GROUP** to release confidential personal information to:

_____

_____

_____

I understand that confidential professional information includes personal, psychological, psychiatric, substance abuse, AIDS related information, medical information, medical records, and opinions resulting from contacts with my treating clinicians. This request specifically to include the following:

☐ Full record disclosure ☐ Discharge Summary ☐ Progress Notes

☐ Psychological Testing ☐ Psychosocial History ☐ History & Physical

☐ Laboratory Results ☐ Other _____

From: _____ To: _____

I also authorize _____ (or one of his/her associates) to

communicate with _____ regarding the above noted request.

I understand that I am not obligated to disclose requested information. I may revoke this consent at any time by informing any of the above individuals. This release of information shall expire, regardless of notification, one year from the signature dates. In consideration of this consent, I hereby release the above parties from any and all liability arising therein.

_____ _____

Patient Name in Print **Patient Date of Birth**

_____ _____

Signature (Patient, Parent, or Legal Guardian) **Date of Signature**