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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____

I request and authorize ACENT to:

- release
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To/From:

Please choose from the following methods:

- Mail
- Fax
- Pick Up

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Address: _____

Phone: _____ Fax: _____

This request and authorization applies to:

- Healthcare information relating to the following treatment, condition or dates:

- All Healthcare Records

- Other:

Additional Information: _____

Patient Signature: _____ Date signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.

INTERNAL USE ONLY

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