

Authorization to Disclose Health Information

Patient Name:	Patient Address:
Date Of Birth:	
Medical Record Number:	

I give permission to:	To release information to:
_____ (Name of Person/Facility)	_____ (Name of Person/Facility)
_____ (Address)	_____ (Address)
_____ (City, State, Zip)	_____ (City, State, Zip)
_____ (Phone Number) (Fax Number)	_____ (Phone Number) (Fax Number)

Check Information to Release:

<input type="checkbox"/> Neuropsychological Evaluation	<input type="checkbox"/> Office Visit Notes
<input type="checkbox"/> Laboratory Reports (B12, TSH, Folic Acid, RPR)	<input type="checkbox"/> Radiology Reports (MRI/ CT Brain)
<input type="checkbox"/> Other (Describe) _____	
Treatment Dates (If Certain Dates are Wanted) _____	

Check Reason for Release: Patient Request Treatment

Release Information: In Person Fax Mail

_____ Patient/Patient Representative Signature	_____ Date
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Legal Authority to sign for patient: ___ Guardian ___ POA Other (Specify) _____

ALZHEIMER'S MEMORY CENTER

