

## Authorization to Disclose Health Information

<b>Patient Name:</b>	<b>Patient Address:</b>
<b>Date Of Birth:</b>	
<b>Medical Record Number:</b>	

<b>I give permission to:</b>	<b>To release information to:</b>
_____	_____
(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

_____	_____
<b>Patient/Patient Representative Signature</b>	<b>Date</b>

**Legal Authority to sign for patient:**    \_\_\_ Guardian    \_\_\_ POA    Other (Specify) \_\_\_\_\_

# ALZHEIMER'S MEMORY CENTER

