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Authorization to Release Records

_____ Psychiatric _____ Alcohol _____ Drug _____ Testing _____ Medical _____ Other

Specific information to be disclosed: _____

_____

Purpose for disclosure: _____

_____

This authorization shall be valid for only _____ days or until this date: _____

This release is subject to revocation at any time by the undersigned.

Release	Obtain
I, _____	I, _____
hereby authorize _____	hereby authorize _____
to release information (checked above) to:	_____
_____	_____
_____	_____
_____	to obtain information (checked above).
Date: _____	Date: _____
_____	_____
Patient/Parent/Legal Guardian:	Patient/Parent/Legal Guardian:
_____	_____
Witness	Witness