Smith Behavioral Health
Anne Smith, Ph.D.
Licensed Psychologist
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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

I request and authorize Anne Smith, Ph.D. to release/receive healthcare information of the patient named above to/from:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ Fax: _____

This request and authorization applies to:

_____ Healthcare information related to mental health treatment

_____ All healthcare information

_____ Other: _____

_____ Yes _____ No I authorize the release of records regarding mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____