Discovery Therapeutic Services

Date-______________
Initial Eval: ________
Reviewed By:_______

HIPPA: PATIENT AUTHORIZATION TO RELEASE MEDICAL RECORDS & INFORMATION

Last Name: __________________________ First Name: __________________________ Date of Birth: _________________

Other name, if applicable: ____

Patient Address: ____

Phone Number: ____

I, ____, authorize the following person (s) to
PRINT PATIENT NAME

receive medical information about me:

Please share information from the following records:

- ☐ All Medical Records
- ☐ Medical Records from _________________________ to _____________________________
- ☐ Records specifically pertaining to ____

NAME RELATIONSHIP PHONE NUMBER

NAME RELATIONSHIP PHONE NUMBER

NAME RELATIONSHIP PHONE NUMBER

PATIENT SIGNATURE ***DATE***