Real Caring
INTEGRATIVE THERAPY

AUTHORIZATION TO REQUEST OR RELEASE INFORMATION

Patient's Name:_____ Date of Birth:_____

I hereby authorize the person(s) or healthcare provider below:

Name_____ Phone_____

Address_____ City_____State_____Zip_____

to release my personal health and medical information to the following person(s) or healthcare provider(s):

Name_____ Phone_____

Address_____ City_____State_____Zip_____

- ❑ All medical records
- ❑ Other:_____

Signed:_____ _____ _____
(Client 18 years of age and older) Date Witness

Signed:_____ _____ _____
(Parent or legal guardian) Date Witness