Advanced Counseling and Testing Solutions, LLC

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name:_____ Date of Birth:_____

Previous Name:_____ Social Security #:_____

I request and authorize ***Advanced Counseling and Testing Solutions, LLC*** to release healthcare information of the patient named above to:

Name:_____

Address:_____

_____

_____

Phone # : _____ Fax# : _____

☐ Healthcare information relating to the following treatment, condition, or dates:

_____

_____

☐ All healthcare information

☐ I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature:_____

Date Signed:

_____

Helping clients is our mission not only our profession!