**Authorization for Release of Information**

We require all information to be completed and accurate

**Please email this form to admin@morsewood.com**

**Patient Information**

**Today’s date:**

Client Name (print)\*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth\*\_\_\_\_/\_\_\_\_\_/\_\_\_\_

Phone Number\*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email\*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I hereby authorize Morsewood Health to:**

* Please choose one\*

Obtain From

Disclose to

Exchange Information

* Provider Name/Facility/Person\*
* City\*
* State\*
* Zip\*
* Phone Number\*
* Fax
* To provide ongoing treatment/aftercare\*

Purpose of Request:

Other:

* **Specific Records/Report (s) to be released:**

Please Write the appropriate information to be released\*

I understand this authorization does not expire unless a written request is submitted to revoke authorization. Disclosure(s) made prior to receipt of revocation are authorized under the prior authorization.

I understand that the confidentiality of my records is protected under Federal Regulations (42CRF, Part 2

I understand that I may be charged for any case consultation that will occur between the listed provider above and my provider.

I have read carefully and understand the above statements and do herein expressly and voluntarily consent to disclosure of the above information and/or medical records to these persons/agencies named above.

Signature of Client or Legal Guardian\*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Client\*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date\*\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_