ADVANTAGE THERAPY CENTERS

Authorization for Release/ Receipt of Information

Patient Name _____ Date _____

I authorized Advantage Therapy Centers to release my medical Records to the below mentioned Physicians/ Hospitals.

(List current Physician – Hospitals)

1. _____
2. _____
3. _____
4. _____
5. _____

READ CAREFULLY: I understand that my medical records are confidential. I understand that by signing this authorization I am allowing the release of my medical information requested to the agency or person specified above. Drug and alcohol abuse information records are specifically protected by federal regulations and by signing this authorization, I am allowing the release of any drug, alcohol, and/or psychiatric information records to the agency or person specified above. I understand that my records may contain information regarding the diagnosis and treatment of HIV (AIDS virus) and other sexually transmitted disease and by signing this authorization, I am allowing this information to be released to the agency or person specified above. I also understand that I may revoke this authorization at any time by written request from myself or my family except to the extent that actions has already been taken in reliance upon it.

This consent shall remain in effect for ninety (90) days from the date executed unless revoked earlier by me. If revoked earlier, it is understood by all parties that the information released prior to being notified of such revocation was made at my request with my consent.

I have read the above and foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this consent.

Date: _____ Signature:_____

(If signed by personal representative, please state relationship/authority to do so.)