Cogent
Family Healthcare

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Re:_____I hereby authorize:_____
_____
_____
To disclose to _____
_____

Records and information pertaining to:

X_____ X_____
Name of patient (list other names used) Date

X_____
DOB

X_____ X_____
_____ _____
Address Telephone

Duration: This authorization shall become effective immediately and shall remain in effect until _____ or for one year from the date of signature.
Date

Specify: Check the box and initial to specify which type of information records is to be disclosed:

***** PLEASE INCLUDE CCD ON DISC *****

___ALL MEDICAL RECORDS (INCLUDES PSYCH, DRUG/ALCOHOL, HIV)
__ PSYCHIATRIC INFORMATION __DRUG /ALCOHOL INFORMATION
__ RESULTS OF AN HIV BLOOD TEST
__OTHER HEALTH INFORMATION (SPECIFY BELOW)
Specify the records to be disclosed_____

The requestor may use the health information authorized on this form for the following purposes only_____
_____

Date:_____ Signature:_____