Authorization for Disclosure of Medical Information

Name of Patient:

Date of Birth:

Address:

**Information to be Released/ Accessed**

Care Plan Lab Reports Progress Reports

Hospital Reports Treatment Record Radiology Reports

History & Physical Operative Report Medication Record

Pathology Reports Complete Records Other

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. I hereby authorize the above information to be released to the following:

**2nd Chance Treatment Center**

**Address: 16620 N. 40th Street Suite I-5**

**Phoenix, AZ 85032**

Signature

Date: