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AUTHORIZATION FOR RELEASE OF INFORMATION

Name: ____

Address: ____

Phone: ____

The above person (or agency) and Dr. Treusch are authorized to communicate by phone, in person, or through records in order to assist them in providing treatment for me or my child.

The patient (or family):

Name:____________________________________

Date of Birth________________________________

Soc. Sec. #:_________________________________

I understand that my records are protected under Federal and other confidentiality regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I certify that this request has been made freely, voluntarily without coercion and the information given is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time.

By releasing information requested you are hereby released from all liability that may arise.

Date:____________________

Signed______________________________
(patient)

Signed______________________________
(parent or guardian)

Witness_____________________________

AUTHORIZATION MUST BE SIGNED BY THE PATIENT, OR BY THE OR GUARDIAN IN THE CASE OF A MINOR.