CREATING HEALTHY ALTERNATIVES TOGETHER

RELEASE OF MEDICAL RECORDS

(Please Print)

Patient's Name: ____________________ Date of Birth: ____________________

Previous Name: ____________________ SSN: ____________________

I request and authorize ____ to release healthcare information of the patient named above to:

Name: Cliff Koblin MA, LPC, LCADC

Address: PO Box 577 4475 Route 27

City: Kingston State: NJ Zip Code: 08528-0577

This request and authorization applies to the use or disclosure of (check all that apply):

☐All healthcare information in my medical record

☐Health care information in my medical record relating to the following treatment or condition: ____

☐Health care information in my medical records for the date(s): ____

☐Other (specify dates): ____

You may use or disclose health care information regarding testing, diagnosis, and treatment for (check all that apply):

☐HIV/ AIDS ☐Psychiatric disorders/mental health
☐Sexually transmitted infections☐Drug and/or alcohol abuse

By signing this, I authorize the release of all information in my medical records, as I have listed, to the person(s) named above.

Patient Signature: ____________________ Date Signed: ____________________

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.