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AUTHORIZATION FOR RELEASE OF INFORMATION

Name: _____

Address: _____

Phone: _____

The above person (or agency) and Dr. Leehey 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.