

### Authorization For Release of Medical Records

|                          |            |
|--------------------------|------------|
| Client's Full Name _____ | DOB _____  |
| Client's Address _____   | City _____ |
| State _____              | Zip _____  |
| Home Phone _____         |            |

***I hereby authorize Partners in Excellence to release medical record information to:***

Mail copies to \_\_\_\_\_

Hold for pick-up at: \_\_\_\_\_ (SITE)

Name/Facility: \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Attention: \_\_\_\_\_

Complete File

Part of File (Please indicate which documents in the file are to be released)

Purpose of Request

\_\_\_\_\_

I understand that this authorization takes effect the day that I sign it. It expires one year from signed date. I also understand that I may change this authorization at any time.

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_