Smiling Spirit Pathways
122 N. Salem St. Suite 201N,
Apex, NC 27502

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____ /_____ /_____

Previous Name (if any): _____ SSN#: _____-_____-_____

I request and authorize _____ to release healthcare information for the patient listed above to:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

This request and authorization applies to:

□ Healthcare information relating to the following treatment, condition or dates: _____

_____

□ All healthcare information

□ Other: _____

I also authorize the release of information regarding mental health treatment to the person(s) listed above.

□ YES

□ NO

Patient Signature: _____ Date signed: _____/_____/_____

Witness: _____ Date signed: _____/_____/_____

THIS AUTHORIZATION EXPIRES NINETY (90) DAYS AFTER IT IS SIGNED