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Release of Information

I, _____, DOB _____ hereby authorize the exchange of information between Radka Chapin and the following party:

Name: _____

Organization: _____

Address: _____

Telephone: _____

Fax: _____

I authorize the following information to be exchanged:

- ☐ general diagnostic information
- ☐ clinical findings
- ☐ attendance
- ☐ general health information
- ☐ for emergency purposes
- ☐ for insurance purposes
- ☐ coordination of care
- ☐ other (specify) _____

This authorization is valid for the course of the treatment and may be revoked or altered at any time per my request.

_____

Printed Name Date

_____

Signature Date