Judith D Alexander, MSW, LISW-CP
315 Miller Rd,
Mauldin, SC 29662

AUTHORIZATION FOR RELEASE OF INFORMATION

I, ___________________________________, Social Security # __________________ hereby authorize:

Name of facility releasing information ____________________________________
Address: ____________________________________
____

to release my record to:

Name of facility/individual/company ____________________________________
Address: ____________________________________
____

For the purpose of:

( ) Continuation of Medical Care
( ) Determination of Benefits
( ) Development and Implement of Aftercare
( ) Involvement in Treatment Process
( ) Processing Insurance
( ) Other ______________________________________

This consent will expire on ________________ or not more than one year following the date of signature. I understand that I may revoke this consent at any time except to the extent action has been taken in reliance thereon. I expressly understand and agree that no legal responsibility or liability of any nature shall attach to the attending physician or facility employee in action upon this authorization and request.

____
Witness

____
Patient

____
Date

____
Parent or Guardian when Applicable

I understand that my records are protected under Federal Confidentiality Regulations (42 CFR) and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

Phone: 864-232-9922 - Email: judithalexandermsw@gmail.com
www.judithalexandermsw.com