The Center for OCD and Anxiety, LLC
244 Center Rd, Ste 301
Monroeville, PA 15146
412-256-8256

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Social Security# _____

I request and authorize _____ to release

healthcare information from the patient named above to:

Name: _____

Address: _____

City: _____ State:_____ Zip Code: _____

Phone: _____ Fax: _____

This request for authorization applies to:

☐ Information relating to the following treatment, condition, or dates:_____

_____

☐ All healthcare information

☐ Other: _____

☐Yes ☐No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person listed above.

Patient Signature: _____ Date:_____

Guardian Signature: _____ Date:_____
For clients younger than 14

Witness Signature:_____ Date:_____

THIS AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED.