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: ________________

I authorize that:

The Center for OCD and Anxiety
244 Center Rd, Ste 301
Monroeville, PA 15146
412-256-8256 (ph) 888-971-4394 (fax)

can release and obtain protected healthcare information related to the above-named patient with the following person/organization:

Name: ____

Address: ____

City: ___________________________________ **State:**_________ **Zip Code:** ________________

Phone: ________________________________ **Fax:** ______________________________________

This request for authorization applies to:

☐ Information relating to the following condition/s, treatment/s, and/or dates:____________________
____

☐ All healthcare information

☐ Other: ____

Patient Signature: ____ Date:_______________

Guardian Signature: ____ Date:_______________
(For clients younger than 14)

Witness Signature:____ Date:_______________

This Authorization Expires One Year After the Date of Patient or Guardian's Signature