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Authorization to Release Information

FIRST NAME: _____ LAST NAME: _____ MAIDEN NAME: _____

DATE OF BIRTH: _____ SOCIAL SECURITY#: _____

Communication between Dr. Flory and your primary care physician (PCP) or others may be important to insure you receive comprehensive health care treatment, but not always necessary. By signing this form you authorize Dr. Flory to exchange information about your treatment history and current treatment with a person of your ***own choice****, such as your PCP.*

PERSON TO CONTACT: PCP OTHER, please specify capacity _____

NAME: _____ PHONE: _____ FAX: _____

STREET: _____ CITY: _____ STATE: _____ ZIP: _____

REASON / NATURE OF INFORMATION TO EXCHANGE:

_____

_____

_____

I herein expressly and voluntarily consent to disclosure of the personal health information (PHI) and/or medical records, including Alcohol and Drug Abuse records, TO and BY the party named above. I understand that this consent is subject to revocation at any time except to the extent that action has been taken in reliance upon it. This authorization will expire within 6 months (or at the date specified here; DATE OF EXPIRATION: _____).

Patient's Signature: _____ Today's Date: _____

Patient Name (PRINT): _____ Date of Birth: _____