NEUROPSYCH PROGRAM
1446 SPAULDING PARK SUITE 303 RICHLAND, WA 99352
Phone: (509) 420 5060 Fax: (509) 420 5059

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Patient Name: _____ Date of Birth: _____

I,_____hereby authorize_____of the RELIANCE HEALTH SYSTEMS to (check one) _____O*btain* and/or _____*Release* my medical, psychiatric, alcohol, drugs, and / or HIV testing, ARC and AIDS diagnosis information contained in my records or disclose information (check one) _____to / _____from:

Name of Facility / Doctor: _____

Address: _____

_____

Phone: _____ Fax: _____

FOR THE PURPOSE OF:
____ Continuation of Treatment ____ Coordination of Care ____ Application for Insurance

____ Legal ____Other (please specify)_____

____ **Complete Record** ____ **Progress Notes Only**

_____ _____
Patient / Legal Representative Signature Date

_____ _____
Provider Signature Date

Approved to Send: _____ **Denied DO NOT Send:** _____