Alamir Health Inc.

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RELEASE OF INFORMATION AUTHORIZATION

By signing this form, I hereby authorize Alamir Health Inc. to:

_______Obtain individual health records

_______Release individual health care records

From/To: Name/Facility: ____

Phone/Fax: ____

Address: ____

I understand that this authorization extends to all or any part of the records/information designated below. This may include treatment for physical and mental illness, alcohol/drug abuse, HIV/AIDS test results or diagnoses. The information released can be verbal or written and includes:

____ Medical Records ____ Treatment Plan ____ Psychiatric Evaluation ____ Progress Notes

____ Consultation Report ____ Medication Records _____FMLA/Disability Paperwork

The purpose of releasing this information is:

____ Continued Medical Treatment ____ Other: ____

I hereby release Alamir Health Inc., and the above-mentioned disclosing/receiving entity from all legal responsibilities or liability that may arise from the use or disclosure of medical records and/or other information.

Expiration: Valid indefinitely unless revoked or according to relevant state law.

Revocation: I understand I have the right to revoke this consent at any time in writing or verbally followed by in writing. Revocation takes effect at the date/time it is received and does not encompass information already released.

Refusal: I have the right to refuse to sign this form. Doing so may terminate treatment relationship.

___________________________	____________	_______________________	__________
Patient/Guardian Signature	Date	Printed Name	Date of Birth