- Main Line Therapeutics————— & Wellness

Authorization Form (Consent for Release of Confidential Information)

This form when completed and signed by you, authorizes me to release protected information from your clinical record to the person you designate.

	and/or his or her adminis ociates, to release (Provide description of the effic and detailed as possible.)	
This information should only be re	eleased to (name and address of person to wh	nom the information is to be released)
	ease this information for the following reaso patient and you do not desire to state a spec	
This authorization shall remain in a individual or the purpose of the use	effect until (fill in expiration date) or until (fe or disclosure).	ill in an event that relates to the
office address. Terms of this consorragreement regarding the release modification will not be effective used to in reliance on the authorization.	uthorization, in writing, at any time by sendent can be altered or modified only in writing of my personal health information. However, antil I am in receipt of your written request, ion prior to that date or if this authorization the insurer has a legal right to contest a claim	g and supercede any verbal discussion er, your revocation and/or request for and to the extent that I have taken was obtained as a condition of
	erally may not condition therapy services up o me for the purpose of creating health infor	
	or disclosed pursuant to the authorization molonger protected by the HIPAA Privacy R	
Signature of Patient	Name of Patient – Printed	Date
	by a personal representative of the pact for the patient must be provided.	atient, a description of such