Sarah A. Bryant, MS, LPC, Counseling

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ________________________ Date of Birth: ____________________
Previous Name: ________________________ Social Security #: __________________

I request and authorize **Anderson Behavioral Counseling** to release health care information of the client named above to:

____

Specific description of the information to be disclosed:

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The purpose of this request is:

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This authorization will expire on: Date:________________ OR when the following occurs:

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____ ______________________
Signature of Patient or Personal Representative Date

Relationship of Personal Representative to the Patient: ____________________________