AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

I request and authorize to release healthcare information of the patient named above from/to:

From: ________________________

Address:________________________

City/State/ZIP__________________

Phone_____________**Fax**_________

To: **Gebhart's Concierge and Consult, LLC**

505 Corporate Center Dr, Suite B

Vandalia, OH 45377

Phone: (937)684-4220 Fax: (937) 684-4320

PATIENT INFORMATION

Patient's Name:___________________________________ **Date of Birth:** _____________________

Social Security #: (last 4 digits)______________________

This request and authorization applies to: (**PLEASE CHECK ALL THAT APPLY**)

All healthcare information ___________________________

Healthcare information relating to the following treatment, condition, or dates: ______

Other: ____________________________

Yes___ No_____ I authorize the release of my medical records, including STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

Yes___ No____ I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: ____

Date Signed: ____

Witness:____

THIS AUTHORIZATION IS VALID FOR 90 DAYS FROM SIGNATURE