KEYSTONE
FAMILY COUNSELING

Phone: 801-380-9305 Fax: 801-609-9302

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Client Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Ext: _____ Fax: _____

To release healthcare information of the above named patient to:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Ext: _____ Fax: _____

This request and authorization applies to:

- ☐ Healthcare information relating to the following treatment, condition, or dates:
  _____
- ☐ All healthcare information
- ☐ Other

☐ 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: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.