4902 S. Val Vista Drive, Suite B106 Gilbert, Arizona 85298
Phone: 480-855-8866 | Fax: 480-855-8867 | gsctherapy2@gsconsultinggroup.com | gsctherapy.com

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name:	Date of Birth: [DOB]
Previous Name:	Social Security #:
I request and authorize GSC Therapy Services to release healthcare information of the patient named above to:	[Name] [Street address] [City, ST ZIP Code]

This request and authorization applies to:

◉ Healthcare information relating to the following treatment, condition, or dates

[List here]

○ All healthcare information ○ Other

[List here]

[Additional information]

○ Yes ○ No I authorize the release of any records or treatment details to the person(s) listed above.

Patient Signature: _____ Date signed: [Date]

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.