PATIENT AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize my medical records including sensitive health information with Bridge To Life Clinical Consultants (BTLCC) be released to

_____

Name of Individual/Facility

via (**must select one option below and enter info**). If requesting health information for personal use, enter email address on file with BTLCC.

- **Fax** _____
- **Email** _____

Patient Name: _____
Date of Birth: _____
Phone number: _____
Address: _____
Date of Request_____
Indicate specific information to be sent _____
_____
Signature (sign or type): _____

- Signing this authorization is voluntary and will not affect my ability to receive treatment from BTLCC. A photocopy or fax of this signed authorization is as valid as the original and will be accepted.
- I may revoke this authorization at any time by notifying BTLCC either in writing or by fax except in instances where BTLCC has already taken action in regards to this authorization.
- This consent form is to be used solely for the release of any health services, medical care, diagnostic tests, treatment planning and management of all clients seen either in-person or via Telehealth services for BTLCC.
- This authorization will expire one (1) year from the dated signature of this authorization or until I revoke it, whichever comes first.