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:

- [x] 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.