consensushealth™

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____

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

_____

_____

_____

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 my sexually transmitted disease (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.

☐ **Yes** ☐ **No:** I authorize the release of my records via email. Please send to:_____

Patient Signature: _____ Date: _____

All completed forms should be emailed to MedicalRecords@consensushealth.com or mailed to:
Consensus Health
Attn: Medical Records
404 Lippincott Drive
Marlton, NJ 08053