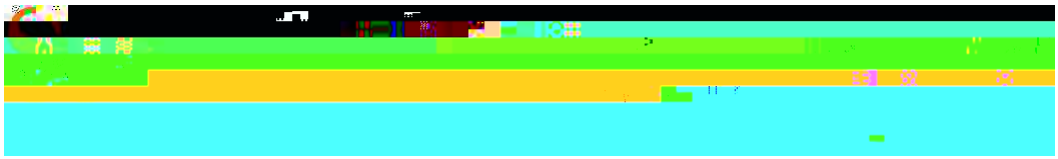

Authorization to Release or Disclose Patient Information

*You are required to submit a separate form for each encounter/request.

Patient Name(print): _____Sam ID: 000_____

Date of Birth: ___/___/_____ Phone: _____ Email:_____

Address:_____

City:_____ State:_____ Zip:_____

Former Students: Please provide your dates of attendance: _____ /_____To _____ /_____
Month Year Month Year