

**RELEASE OF INFORMATION**

**Patient:** \_\_\_\_\_

**Physician/Treatment Provider:** \_\_\_\_\_

I, \_\_\_\_\_ (Patient/Legal Guardian) do hereby authorize the attending physician, the hospital or other health care agencies that will be providing care to release to Inner Door Center any information related to the development, implementation and evaluation of my individual treatment plan, and to the payment of claims for services.

**Information needed:**

**All Pertinent Medical Records**

\_\_\_\_ (check if applicable) I consent to have any of my medical record information used for research purposes.

**I understand that I should retain a copy of this signed release form and that a photocopy of this form is as valid as the original.**

\_\_\_\_\_  
**Date and Time**

\_\_\_\_\_  
**Signature (Patient/Legal Guardian)**

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