LISA B. KELLY, LCSW, LLC
616 East Colfax Ave, South Bend, Indiana 46617
Phone: 574-289-7000, ext. 2 Fax: 866-610-1948

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize Lisa B. Kelly, LCSW to release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

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 any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.