

**AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION**

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Previous Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

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

Name: Deanna Moncrief, MS, CNS

Address: Post Office Box 2004

City: Kailua State: HI Zip Code: 96734

This request and authorization applies to:

Healthcare information relating to the following treatment, condition, or dates:

\_\_\_\_\_

All healthcare information

Other: \_\_\_\_\_

Purpose of disclosure: \_\_\_\_\_

The information may be communicated in the following manner:  Oral  Written

I understand that I may revoke this consent at any time by notifying the provider in writing.

Patient Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

Relationship to patient if unable to sign \_\_\_\_\_

Witness \_\_\_\_\_

**THIS AUTHORIZATION EXPIRES THREE (3) MONTHS AFTER IT IS SIGNED.**