# Michael S. Greenbaum, M.D., S.C.

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## AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

**RE:** _____

I authorize and request that:

**AGENCY OR INDIVIDUAL:**

Name: _____

Address: _____

City, State, Zip: _____

Phone Number: _____

Fax Number: _____

Release confidential protected health information including: personal, psychiatric, medical, laboratory, psychological testing, social, educational, substance abuse, clinical information and opinions regarding myself and (if applicable) re-release of _____

TO: **Michael S. Greenbaum, M.D., S.C.**

Dr. Greenbaum is likewise authorized to release said information to the above party **YES / NO**

This authorization is valid for 12 months from date of signing and limited to only that information that I have requested above to be release to the person named herein. The purpose of the release of information is to assist in providing complete care. All information released can be inspected and copied by the client. It is understood that I have the right to revoke the consent contained herein at any time during its validity.

_____
Signature of patient (if over 12 years)

_____
Signature of Parent/Guardian
(if under 18 years)

_____
Date

_____
Signature of Witness