Phone: (630) 217-9911
2132 Deep Water Ln, #240
Naperville, IL 60564
Fax: (630) 596-8636
www.greenpathclinic.com

Authorization for Release of Information

Patient Name: ____ DOB: ___ / ___ / _____
Address ____
Phone Number: (_____) __________________

I, ____

(Patient/Guardian Name)

authorize ______________________GreenPath Clinic ____________________________
to disclose to ____
____
____

(Name, Address, Phone/Fax Number)

The following specific information from my records: _______________________________
____
____
____
____

I understand that this release will expire one year from date signed. I may withdraw this consent by giving written notification to the GreenPath Clinic at any time. I understand that I cannot withdraw consent retroactively for information exchanges that have already occurred.

Patient Signature: ______________________________________ Date: ___ / ___ / _____