3069 S. Broad St. #7d - Chattanooga, TN 37408 - 423.517.7070 - www.elbowtree.com

Authorization for Release of Information

I, ________________________________, authorize Sarah Hopcroft, M.A. to:
(patient or guardian)

______ provide information as indicated: ________________________________

______ exchange information as indicated: ________________________________

______ receive information as indicated: ________________________________

regarding ______________________________ treatment and status to/with/from:
(patient's name) (circle)

Name:____

Street: ____

City: ____

State: _____________________________ Zip: ______________________________

Phone: _____________________________ Fax: ______________________________

I understand that I may revoke this consent at any time by written request to the authorized person. The revocation is effective on the date the request is received and placed in the medical record.

Patient's DOB___/___/___ and SS#:_____________________________

______________________________ ______________________________

Signature Date Witness Date
(Patient or Guardian)