AUTHORIZATION TO RELEASE INFORMATION

Patient's Name _____

DOB _____

I hereby knowingly and voluntarily authorize In Step, P.C. to exchange treatment information with the following person(s).

Name(s) _____

Address of Person(s) _____

_____

Phone Number(s) _____

Email Address _____

Effective Date of Authorization _____

I understand that I must deliver written revocation to In Step, P.C. at 8500 Executive Park Avenue Ste. 204 Fairfax, Virginia 22031 if I no longer authorize this release of information.

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by privacy regulations.

This authorization expires one month after the final date of treatment at In Step.

Printed Name_____

Authorized Signature_____

Date_____

Relationship to Patient_____

Signature of Witness_____

Date_____