



Advanced Counseling and Testing Solutions LLC
2121 Oregon Pike, Suite 201
Lancaster, PA 17601
(717) 208-6599
www.ACTSofLancaster.com

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize **Advanced Counseling and Testing Solutions, LLC** to release healthcare information of the patient named above to:

Name: _____

Address: _____

Phone # : _____ Fax# : _____

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

- All healthcare information
- I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient

Signature: _____

Date Signed:

Helping clients is our mission not only our profession!