Care Coordination Authorization

I, _____, hereby expressly authorize _____ (insert name of disclosing provider) to release and disclose all medical and counseling records to _____ (insert name of receiving provider), for the purpose of coordinating my healthcare. I understand my records are confidential and cannot be disclosed without my written consent, unless otherwise provided for in state or federal regulations. This consent is subject to revocation at any time except to the extent that action has been taken in reliance on it. If not previously revoked, this consent will terminate upon _____ (insert termination date).

_____ _____ _____

Signature (Patient or Legal Guardian) Print Name (Patient or Legal Guardian) Date

MEDICAL MUTUAL®