THE YANUCK CENTER
for Life and Health

Consent to Release & Exchange Protected Health and Account Information

I, _________________________, give my consent for Dr. Cheryl Yanuck to give and/or receive information concerning my medical care (including information related to mental health and/or substance abuse, if applicable) to/from (name, address, phone, fax):

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This information shall be limited to:

__all medical records (outpatient/inpatient) __medication records

__Lab & radiology test results ___psychological testing reports ___Account/appointment info

__Other:____

Reason for disclosure: ___Continuity of Care ___Transfer of Care ___Insurance

___Disability/FMLA__Other:____

This consent will expire on ________________ or when I inform Dr. Yanuck that I revoke my consent.

Signature:____________________________________

Date:__________________

Date of Birth:_________________________

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