ALPS Adult Day Services

MEDICAL INFORMATION RELEASE FORM

To the Doctor(s) of ___________________________________:

participant's name

I hereby authorize you to release to ALPS Adult Day Services any and all medical or confidential information contained in the record of:

full name of participant: ______________________________________

date of birth: ______________________________________

address: ______________________________________

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I further authorize ***ALPS Adult Day Services*** *to release any and all health information contained in the ALPS health records to any doctor who is providing treatment for* ___________________________________:

participant's name

________________________________ ________________

patient or authorized representative *date*

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phone

Please fax or mail information to ALPS at:

fax 423.587.9234

phone 423.587.9149

600 N. Daisy St.

Morristown, TN 37814