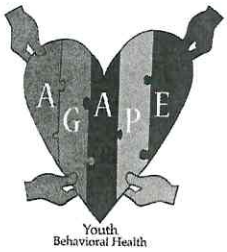

Agape Youth Behavioral Health
1360 Mackey Branch Drive
Chattanooga, TN 37421
423.443.3336

Authorization to Release Healthcare Information

Patient's Name:_____ Date of Birth:_____

I request and authorize _____Agape Youth Behavioral Health and Providers_____

To _____ **release** and/or _____ **obtain** health care information of the patient names above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

This request and authorization applies to:

☐ Coordination of Care
☐ Continuity of Care
☐ Legal Purposes
☐ Other: _____

All information available may be released including psychological testing, lab testing, and any other reports, except as listed: _____
_____

Signature: _____ Date: _____
Printed Name: _____
Relationship to Patient: ☐ Self ☐Parent/Legal Guardian

THIS AUTHORIZATION IS VALID FOR ONE YEAR UNLESS REVOKED BEFORE THAT TIME.
FORM MUST BE FILLED OUT COMPLETELY.