QUEST THERAPEUTIC CAMPS
2209 Ardmore Blvd
Pittsburgh PA 15221
(412) 877-7528 800-313-9733 FAX:925-820-9761

April Artz,MS, NCC, LPC, Director

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize April Artz,MS, NCC, LPC ,Quest Therapeutic Camps, Inc. to release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This request and authorization applies to:

☐ Healthcare information relating to the participation in the Quest Therapeutic program _____

_____

☐ All healthcare information

☐ Other: _____

☐ Yes ☐ No I authorize the release of any records regarding my child's mental health treatment to the person(s) listed above.

Parent /Guardian Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES 365 DAYS AFTER IT IS SIGNED.