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AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ hereby voluntarily authorize the disclosure of
(Name of Patient)
information from my health record.

Patient Information:

Patient Name: _____ DOB: _____

Address: _____ Phone #: _____

Information Requested:

_____

_____

_____

Purpose of Release:

_____

_____

The Information Is To Be Provided To:

Name of Person/Organization/Facility: _____

Address: _____

Phone Number: _____

_____ _____
Patient's Signature or Patient's Representative Date

_____ _____
Printed Name of Patient's Representative Relationship of Patient

This information is to be released for the purpose stated above and may not be used by recipient for any other purpose.

HIPAA Authorization For Release of Medical Records

PLEASE MAKE A COPY OF THIS RELEASE FOR YOUR RECORDS