Authorization to Release Health Information

This authorization will expire twelve (12) months from the date signed.

Patient Name: _____ Date of Birth: _____

I request and authorize _____

Address/City/State/ Zip (of office listed above) _____

Phone: _____ Fax: _____

To release the medical record of the above-named patient to:

Name of recipient: _____

Address/City/State/Zip _____

Reason for release: _____

This request and authorization applies to: ***PLEASE initial next to the appropriate line.***

_____ALL healthcare information on file

_____Most recent healthcare information on file.

Please allow TEN (10) to FOURTEEN (14) business days to process your request.

Please initial the following acknowledgement:

_____ I understand I have the right to revoke this authorization by providing a written request to do so to the above-named practice or organization. I understand that the revocation will not apply to information that has already been released.

_____ _____

Signature of patient or authorized representative Date