Authorization for Release of Medical Information

Date: _____

To: [Recipient Name]

Address: [Recipient Address]

Patient Name: _____

Date of Birth: _____

Medical Record Number: _____

I, the undersigned, authorize the release of my medical information to the individual or organization listed below.

Recipient Information

Name: _____

Address: _____

Phone Number: _____

Purpose of Disclosure

Please specify the reason for the disclosure: _____

Information to be Released

Please include the following medical records: _____

This authorization is valid until _____ (date) unless revoked in writing.

I understand that I have the right to revoke this authorization at any time by submitting a written request to the provider.

Signature: _____

Printed Name: _____

Date: _____