Medical Document Release Authorization

Date: [Insert Date]

Patient's Name: [Insert Patient's Name]

Patient's Address: [Insert Patient's Address]

Patient's Date of Birth: [Insert DOB]

Phone Number: [Insert Phone Number]

Authorization Statement

I, the undersigned, authorize the release of my medical records as specified below:

Recipient Information

Recipient Name: [Insert Recipient Name]

Recipient Address: [Insert Recipient Address]

Phone Number: [Insert Recipient Phone Number]

Information to be Released

Please release the following medical records:

- [Specify type of record] - [Date range]
- [Specify type of record] - [Date range]

Purpose of Release

The purpose of this release is for [Insert Reason].

Expiration of Authorization

This authorization will expire on [Insert Expiration Date] or until revoked in writing.

Signature

Patient Signature: _____

Date: _____

Notice

Revocation of this authorization must be made in writing.