Medical Information Release Authorization

Patient Name: [Patient's Full Name]

Date of Birth: [Date of Birth]

Address: [Patient's Address]

Recipient Information

Name: [Recipient's Name]

Organization: [Recipient's Organization]

Address: [Recipient's Address]

Authorization

I hereby authorize the release of my medical information as follows:

- **Type of Information:** [Specify the medical information to be released]
- **Purpose of Release:** [Specify purpose]

Expiration

This authorization will expire on [Expiration Date]. If no date is specified, this authorization will expire in one year.

Signature

Signed: _____

Date: _____

Contact Information

If you have any questions regarding this authorization, please contact:

Name: [Contact Person's Name]

Phone: [Contact Phone Number]