Medical Record Release Authorization

Patient Name: _____

Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____

Recipient Information:

To: _____

Address: _____

City: _____ State: _____ Zip: _____

Authorization:

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

Specific Records Requested: _____

Date Span of Records: _____

Purpose of Release:

Purpose of Release: _____

Expiration of Authorization:

This authorization will expire on: _____

Patient Signature:

Signature: _____

Date: _____

Witness Signature:

Witness Name: _____

Signature: _____

Date: _____