Health Information Release Form

Date: [Insert Date]

To Whom It May Concern,

I, [Resident's Full Name], residing at [Resident's Address], hereby authorize the release of my health information to the following individuals:

Recipient Name: [Name of the Individual/Organization]

Relationship to Resident: [Relationship]

Contact Information: [Phone Number and/or Email Address]

This release includes:

- Medical history
- Treatment records
- Prescriptions
- Any other relevant health information

This authorization will remain in effect until [Date, or "revoked in writing"].

Thank you for your attention to this matter.

Sincerely,

[Resident's Signature]

[Resident's Printed Name]

[Resident's Date of Birth]