

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

TO REQUEST RELEASE OF MEDICAL INFORMATION PLEASE COMPLETE AND SIGN THIS FORM

I, _____ hereby voluntarily authorize the disclosure of information from my health record. (Name of Patient)

Patient Information:

Patient Name: _____ Record Number: _____

Address: _____ Date of Birth: _____

Information Requested:

Purpose of Release:

The Information Is To Be Provided To:

Name of Person/Organization/Facility: _____

Address: _____

Phone Number: _____

Patient's Signature or Patient's Representative

Date

Printed Name of Patient's Representative

Relationship of Patient

This information is to be released for the purpose stated above and may not be used by recipient for any other purpose.

PLEASE MAKE A COPY OF THIS RELEASE FOR YOUR RECORDS

HIPAA Authorization For Release of Medical Records