AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

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

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

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Medical Record Number: _____

Address: _____

INFORMATION REQUESTED_____

PURPOSE OF RELEASE_____

INFORMATION TO BE RELEASED TO:

Name of Person/ Organization, or Facility: _____

Address: _____

Phone Number: _____

_____ _____

Patient's Signature or Patient Representative's Signature **Date**

_____

Printed Name of Patient or Patient Representative

Relationship to Patient: _____

This information authorized for release by this form is to be used solely for the purpose stated above and may not be used by the recipient for any other purpose.

PLEASE MAKE A COPY OF THIS RELEASE FOR YOUR RECORDS.