RELEASE OF INFORMATION

Patient Name _____ Date of Birth ____/_____/____

SSN ____ - ____ - ____ Address _____

City _____ State_____ Zip Code _____

INFORMATION TO BE DISCLOSED

I authorize the release of the following health information (check applicable box below):

⬜ All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me

⬜ Only the following records or types of health information:

_____

_____

INFORMATION REQUESTED FROM

Name _____

Address _____ City _____ State _____

Zip Code _____ Phone ( ) _____ Fax ( ) _____

Email _____

SEND INFORMATION TO

Name _____ Send by ⬜ Mail ⬜ Fax ⬜ Email

Address _____ City _____ State _____

Zip Code _____ Phone ( ) _____ Fax ( ) _____

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Email _____

TERM
I understand this authorization that this Authorization will remain in effect:

⬜ From the date of this Authorization until _____ (date)
⬜ Until the provider fulfills this request
⬜ Until the following event occurs: _____

I,_____ (Name), hereby grant permission to release confidential health information about me, by releasing a copy of my medical record, or a summary or narrative of my protected health information, to the health professional listed above.

Printed Name _____ Date _____

Signature _____ Date _____

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