Authorization to Obtain Medical Documentation

I hereby authorize the release of my medical records as described below.

Patient Name:

Date of Birth:

Name of Medical Provider or Facility:

Description of information to be disclosed:

Purpose of Disclosure:

Recipient (Person/Organization Authorized to Receive Information):

Authorization Expiration Date:

Signature of Patient or Legal Representative:

Date Signed:

Submit

I understand that this authorization is voluntary and that I may revoke it at any time in writing, except to the extent that action has already been taken.