Authorization to Release Health Records

I hereby authorize the release of my health records as described below:

Patient Name:

Date of Birth:

Release Records To (Name/Organization):

Address:

Phone Number:

Purpose of Disclosure:

Specific Information to be Released:

Effective Dates of Records:

I understand that this authorization is voluntary and I may revoke it at any time by providing written notice. This authorization will expire on:

Signature:

Date: