Medical Records Information Authorization

Patient Information

Full Name: [_____]

Date of Birth: [_____]

Address: [_____]

Authorization Details

Name of Provider or Facility: [_____]

Recipient Name (who will receive records): [_____]

Date(s) of Service Requested: [_____]

Information to Release: [_____]

Authorization Period

Authorization Start Date: [_____]

Authorization End Date: [_____]

Signature

Signature: [_____]

Date: [_____]

[Submit]