Authorization to Disclose Medical Information

Patient Name:

Date of Birth:

Address:

Phone Number:

Healthcare Provider or Facility Authorized to Disclose Information:

Person/Organization to Receive Information:

Information to be Disclosed:

Purpose of Disclosure:

Expiration Date or Event:

Signature of Patient or Legal Representative:

Date:

I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on it. I also understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations.