Authorization to Disclose Medical Records

Patient Name:

Date of Birth:

Address:

Phone Number:

Name of Provider/Doctor:

Purpose of Disclosure:

Type of Information to be Disclosed:

- [ ] All Medical Records
- [ ] Laboratory Results
- [ ] Imaging Reports
- [ ] Other (specify below)

Recipient Name/Organization:

Recipient Address:

Recipient Phone Number:

- [ ] I authorize the disclosure of my medical records as described above.

Signature:

Date:

Submit