Authorization for Health Record Transfer

Patient Information

Full Name:

Date of Birth:

Address:

Phone Number:

Records To Be Released From

Facility/Doctor Name:

Facility Address:

Records To Be Released To

Facility/Doctor Name:

Facility Address:

Information to be Released

- [ ] All Health Records
- [ ] Specific Records (Please Specify Below)

Authorization

I hereby authorize the release and transfer of my health records as indicated above. This authorization is valid for one year from the date signed or until revoked in writing by me.

Signature:

Date:

Submit