Agreement for Use and Disclosure of Health Records

This Agreement is entered into by and between:

Patient Name:
Date of Birth:
Address:

and

Healthcare Provider/Institution:
Contact Information:

Purpose of Disclosure

Authorization Terms

The undersigned hereby authorizes the use and disclosure of the health records specified below for the purpose stated above.

Records to be disclosed:
Time period covered:

This authorization is valid until:

Signatures

Patient Signature:
Date:

Healthcare Provider Representative:
Date: