Authorization to Release Medical Records

Patient Information

Full Name:

Date of Birth:

Address:

Phone Number:

Recipient Information

Recipient Name/Organization:

Recipient Address:

Recipient Phone Number:

Records to be Released

Type of Records:

Date(s) of Service (if applicable):

Authorization

Purpose of Release:

☐ I authorize the release of my medical records as described above.

Signature:

Date:

Submit