Authorization for Medical Information Exchange

I, _____, hereby authorize the exchange of my medical information as described below:

Date of Birth: _____

Medical Record Number: _____

Health Care Provider/Facility authorized to exchange information: _____

Recipient of Information: _____

Purpose of Information Exchange: _____

Type(s) of Information to be disclosed (check all that apply):

- ☐ Medical History
- ☐ Test Results
- ☐ Immunization Records
- ☐ Other (please specify): _____

This authorization is valid until (date): _____

I understand that I may revoke this authorization in writing at any time.

Signature: _____

Date: _____