

# Authorization to Release Health Information Form

## Patient Information

Full Name:

Date of Birth:

Address:

## Receiving Party

Name/Organization:

Address:

## Information to be Released

☐ All Health Information

☐ Specific Information (please specify):

## Purpose of Release

Expiration Date/Condition:

☐ I understand this authorization can be revoked in writing at any time.

Signature:

Date:

Submit