

Patient Authorization for Information Sharing

Patient Name:

Date of Birth:

Name of Provider/Organization:

Information to be Shared (check all that apply):

- ☐ Medical Records
- ☐ Mental Health
- ☐ Billing Information
- ☐ Other

Recipients of Information:

Purpose of Sharing Information:

Expiration Date of Authorization:

Patient Signature:

Date Signed:

Submit