Healthcare Records Authorization Form

Patient Information

Full Name: _____

Date of Birth: _____

Address: _____

Phone Number: _____

Recipient Information

Recipient Name/Organization: _____

Recipient Address: _____

Recipient Phone: _____

Authorization Details

Records to be Released: _____

Purpose of Release: _____

Dates of Records (From-To): _____

Signature

Signature: _____

Date: _____

[Submit]