Authorization for Medical Information Sharing

I, _____, born on _____ , hereby authorize the release of my medical information as described below.

Name of Healthcare Provider releasing information: _____

Name of person/organization to receive information: _____

Type of information to be shared: ☐ Medical History
☐ Diagnosis
☐ Treatment
☐ Other _____

Purpose of information sharing: _____

This authorization is valid until: _____

Signature of Patient: _____

Date: _____

Submit