Release of Health Records Authorization

I, _____, hereby authorize the release of my health records as detailed below.

Patient Information

Full Name: _____

Date of Birth: _____

Address: _____

Phone Number: _____

Recipient Information

Name of Person/Organization receiving records: _____

Address: _____

Phone Number: _____

Information to be Released

- ☐ Entire Health Record
- ☐ Specific information (please specify): _____

Purpose of Release

_____

Authorization

Signature: _____

Date: _____

Submit