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## AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

### Patient Information

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
City/State: \_\_\_\_\_ SSN: \_\_\_\_\_

### I. Release Information

Information to be released from: \_\_\_\_\_  
Name & Address of Facility/Provider \_\_\_\_\_

Information to be released to: Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_

Information to be released:  
 All medical records  
 Medical records for the following dates: \_\_\_\_\_  
 Medical records relating to the following treatment/condition:  
\_\_\_\_\_  
 Other (e.g. X-rays, bills): \_\_\_\_\_

Reason for the release:  
 Personal  Doctor  Attorney  Insurance  Other \_\_\_\_\_

### Patient Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing.

\_\_\_\_\_  
Patient or legally authorized individual signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name if signed on behalf of the patient

\_\_\_\_\_  
Relationship  
(parent, legal guardian, personal representative)