

# AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Name of Patient	
Address	
Phone Number	E-mail
Birthdate	Social Security Number
Other Aliases	

Name of Guardian or Legal Representative	
Address	
Phone Number	E-mail

I hereby authorize the following health care professional, medical facility, mental health facility, laboratory, paramedical facility, medical examiner, medical records service, prescription history clearing house, consumer reporting agency, employer, or family member to release (Check one)  all health information about me  Other: \_\_\_\_\_

Person/Organization to Release Information		
Street Address		
City	State	Zip Code
Phone Number	Fax Number	

I understand that I have a right to revoke this authorization at any time. I understand that the revocation will not apply to information that has already been used or disclosed in response to this authorization. Unless otherwise specified, this authorization will expire in 90 days.

Signature \_\_\_\_\_ Date \_\_\_\_\_

If signed by Legal Representative, Relationship to the Patient \_\_\_\_\_

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