Blank Medical Release Authorization Form for Care Facilities

Patient Name:

Date of Birth:

Phone Number:

Facility Name:

Facility Address:

Authorization:

I hereby authorize the release of my medical records and relevant health information to and from the care facility listed above for purposes of coordination and provision of care.

Specific Records to Be Released (optional):

Purpose of Release:

Signature of Patient / Legal Guardian:

Printed Name:

Date:

Note: This authorization is valid for one year from the date signed unless otherwise revoked in writing.