Health Information Release Authorization

Patient Information

Full Name

Date of Birth

Address

Phone Number

Recipient of Information

Name/Organization

Address

Phone Number

Information to be Released

Description of information to be released

Purpose of Release

Purpose

Authorization Expiration

This authorization will expire on

I authorize the release of my health information as described above. I understand that this authorization is voluntary and that I may revoke it in writing at any time, except to the extent that action has already been taken in reliance on this authorization.

I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by law.

Signature of Patient/Representative

Date

If signed by Representative, state relationship to patient