AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name _____ **Date of Birth** _____

The above named person must indicate when this authorization is to expire:

- ☐ When information is received
- ☐ In six months
- ☐ On date _____
- ☐ In one year
- ☐ In three years

The person named above is or has been a patient of

Name of Person, Provider, or Facility _____

Address _____

Phone _____

Fax _____

The person named above hereby authorizes _____ **to**

Name of Person, Provider, or Facility

- ☐ Request health information from
- ☐ Discuss health information with
- ☐ Send health information to
- ☐ Discuss health information with

The person named above authorizes information to be requested or released by representatives of

Name Of Person, Provider, Or Facility _____

Address _____

Phone _____

Fax _____

Scope

- ☐ All information regarding assessment, diagnosis, and treatment of patient's condition, concern, or disease (specify):

  _____

- ☐ All information regarding care received by patient between the dates of _____ (Starting Date) and _____ (Ending Date)
- ☐ Other information (specify):

  _____

Authorization

_____

Printed name of Patient or Authorized Representative

_____ Signature of Patient or Authorized Representative

_____ Date

_____ Signature of witness

_____ Date

If not signed by the patient, indicate relationship of authorizing person to patient:

- ☐ Parent or guardian of minor child
- ☐ Guardian or conservator of conserved patient
- ☐ Beneficiary or personal Representative of a deceased individual