AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, _____ (____/____/____ ____-____-____).
Patient's Full Name | Date of Birth | Social Security Number

Hereby authorize and request: _____
Healthcare Provider

_____
Address(Street, City, State, Zip Code)

To provide records to: _____
(Example: Healthcare Provider, Company, Patient)

_____
Address (Street, City, State, Zip Code)

PLEASE SPECIFY THE RECORDS TO BE RELEASED: _____

_____

I authorize you to release all of the information requested, without limitations placed on dates, history of illness, and/or diagnostic information:

REASON FOR RELEASE: _____
(Example: Moving, Second Opinion, Personal)

The information to be released is confidential. Further disclosure by the receiving party is strictly prohibited except as specifically authorized.

I understand that I may revoke this consent at any time, except if action has already been taken in regards to this request. This consent automatically expires upon compliance of this request and will not serve for any further request.

SIGNATURES:

_____ ____/____/____
Patient | Date Signed

_____ ____/____/____
Legal Guardian (if under the age of 18, or if POA is assigned) | Date Signed

_____ ____/____/____
Witness | Date Signed