Release of Medical Information

Patient Information

Name: _____

Date of Birth: _____ Phone: _____

Address: _____

City, State, ZIP: _____

Authorization to Release Information

I, the undersigned, authorize the release of my medical information to:

Recipient Name: _____

Organization: _____

Phone: _____ Fax: _____

The information released may include:

- General Medical Records
- Lab Results
- Treatment Plans
- Billing Records
- Other: _____

Purpose of Disclosure: _____

I understand that I have the right to revoke this authorization at any time by submitting a written request. This authorization will remain in effect until revoked in writing or upon the expiration date listed below.

Expiration Date: _____

Signature: _____ Date: _____