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Authorization to Release Medical Records/Information

Patient Name: ____

Social Security Number: _________________________ Date of Birth: __________________

I authorize the following Physician or Facility to **release** information:

Physician/Facility Name: ____

Address: ____

Phone Number: ________________________ Fax Number: __________________________

Please release: ☐ All records ☐ Physician notes ☐Lab results

Person/Physician/Facility to **accept** records:

Name: ____

Address: ____

Phone Number: _______________________ Fax Number: ____________________________

Expiration or revocation of authorization: I understand that I may revoke this authorization at any time and unless an earlier date is specified this authorization will expire 12 months after the date affixed below. I authorize copies of this form to be utilized with the same effectiveness as an original.

I authorize the health care provider to provide the information specified above.

__________________________________	___________________________________
Patient/Guardian Signature	Printed Name
__________________________________	___________________________________
Witness	Date