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Patient Information: Print name: ______________________________ Date of Birth: _________________________

SS#: ___________________________________ Maiden or prior name: ________________________________

Please release my healthcare information from:

Name of Facility/Provider : _______________________

Address: _______________________________________

City/State/Zip: __________________________________

Phone Number: _________________________________

Please release my healthcare information to:

Name of Designated Recipient: _______________________

Address: ____

City/State/Zip: ______________________________________

Phone Number: ___________________________________

Information to be released:

- ❑ The most recent 2 years of pertinent information (chart notes, and special tests)
- ❑ All medical records
- ❑ Specific information (please specify)

Purpose for which disclosure is being made:

- ❑ Sharing with other health care providers
- ❑ Personal use
- ❑ Legal investigation
- ❑ I am transferring my care to a new health care provider
- ❑ Other: ____

My Rights:

I understand that I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws. **THIS AUTHORIZATION WILL EXPIRE 90 DAYS FROM THE DATE SIGNED.**

Signature ____ Date _______________________________

(Patient, Guardian, Authorized Representative)

Printed Name of Authorized Representative: ___________________________ Relationship to Patient _______________