

Medical Consent to Release Health Records

Patient Information

Full Name

Date of Birth

Address

Recipient Information

Person or Organization Authorized to Receive Records

Address

Information to be Released

Description of Health Information to Be Released

Purpose of Release

Purpose

Authorization

I authorize the release of my health records as indicated above.

Signature of Patient/Authorized Representative

Date

If signed by representative, relationship to patient

Expiration Date of This Authorization

