## **HIPAA Authorization for Information Release**

## **Patient Information**

Full Name
Date of Birth
Address
Phone Number
Recipient Information
Person/Organization to Receive Information
Address
Phone/Fax
Information to be Released
Specify information to be released
D (D' )
Purpose of Disclosure
Purpose
Authorization Expiration
Expiration Date or Event

## Signature

ignature of Patient or Authorized Representative	
ate	
signed by representative, describe authority	