Medical Authorization to Release Information

Patient Information

Full Name
Date of Birth
Phone Number
Address
Release Information To
Recipient/Facility Name
Phone/Fax
Address
Information to be Released
Specific information to be released
Specific Information to be released
Purpose of Disclosure
Purpose

Authorization

I hereby authorize the release of the specified medical information as indicated above.

Patient's Signature

Date				
If signed by authorized re	oresentative, plea	ase indicate:		
Relationship to patient				