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AUTHORIZATION TO RELEASE PATIENT INFORMATION

PATIENT NAME:_________________________________ Maiden/other name:_______________

DATE OF BIRTH:_____________________________ SSN:_______________________________

PATIENT RECORDS **From:**____

Physician/Medical Office

____

Address

____

City State Zip Telephone

I hereby authorize and request the release of the following information:

________All Patient Information
________Patient Information for visit date(s) of ___________to___________
________All Billing Statements
________Other (specify):____

PLEASE SEND MY RECORDS TO:

____

____

Address

____

City State Zip Telephone

Purpose for release of information:____

____

Upon request, you may limit the amount of time that this consent for release of information is valid. You may revoke this authorization in writing at any time. I understand that the revocation will not apply to information that has already been released. I understand that authorizing the disclosure of this information is voluntary. I can refuse to sign this authorization and know that I do not need to sign to assure treatment. I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure by the recipient. Photocopies or facsimile of this Authorization shall be considered to be the same as a signed original document.

Signature:_______________________________________ **Date:**__________________________

(Type first and last name if electronic signature)

Relationship to patient (If parent or guardian):_____________________________________

Office Use Only Released:
Date___________to:____________________________by:____________________________
Date___________to:____________________________by:____________________________