Medical Information Release Form
Patient Information:
- Name: _____
- Date of Birth: _____
- Address: _____
- Phone Number: _____
Recipient Information:
- Name: _____
- Organization: _____
- Address: _____
- Phone Number: _____
Description of Information to Be Released:
- [ ] Entire Medical Record
- [ ] Specific Treatment Records (please specify): _____
- [ ] Laboratory Results
- [ ] Imaging Reports
- [ ] Other: _____
Purpose of Release:
- [ ] Continuation of Care
- [ ] Insurance Purposes
- [ ] Legal Purposes
- [ ] Other: _____
Expiration of Authorization:
This authorization will expire on: _____ or will remain in effect until revoked in writing.
Patient Authorization:
I hereby authorize the release of my medical information as described above.
- Patient Signature: _____
- Date: _____
If patient is a minor or unable to provide authorization, please complete the following:
- Authorized Representative Name: _____
- Relationship to Patient: _____
- Signature of Authorized Representative: _____
- Date: _____
Revocation of Authorization:
I understand that I have the right to revoke this authorization at any time by submitting a written request to the healthcare provider.
Contact Information for Further Inquiries:
- Phone Number: _____
- Email: _____
Notice:
This information may be subject to re-disclosure and may no longer be protected.