

# Third Party Medical Information Authorization Form

This form authorizes the disclosure of protected health information to a designated third party. Please complete all sections to ensure proper processing.

## 1. Patient Information

Patient Full Name:

Date of Birth (MM/DD/YYYY):

Phone Number:

Street Address:

City, State, Zip Code:

## 2. Authorized Third Party (Recipient)

Authorized Person or Organization Name:

Relationship to Patient:

Phone Number:

Street Address:

City, State, Zip Code:

## 3. Scope of Medical Information to Disclose

Please describe the specific medical records or information authorized for release (e.g., "All medical records," "Lab results from January 2023," "Billing statements"):

## 4. Purpose of Disclosure

Please state the reason for this authorization (e.g., "At the request of the individual," "Legal claim," "Insurance evaluation"):

## 5. Expiration and Revocation

This authorization will automatically expire one year from the date of signature unless a different date or event is specified below:

Expiration Date or Specific Event:

I understand that I have the right to revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on this authorization.

## 6. Authorization Signature

By signing below, I acknowledge and agree to the release of my protected health information to the third party listed above.

Signature of Patient or Personal Representative:

Date Signed (MM/DD/YYYY):

If signed by Personal Representative, state relationship to Patient: