Release of Information Authorization Form

This form authorizes the disclosure and/or release of protected health information in accordance with federal and state laws.

1. Patient Information

Full Name:

Date of Birth (MM/DD/YYYY):

Phone Number:

Email Address:

Mailing Address:

2. Authorizing Entity (Who is holding and releasing the information)

Name of Facility or Provider:

Address:

Phone Number:

Fax Number:

3. Receiving Entity (Who is authorized to receive the information)

Name of Individual or Organization:

Address:

Phone Number:

Fax Number:

4. Description of Information to be Released

Please specify the records you wish to release (e.g., "All medical records", "Billing records", "Lab reports from June 2023"):

Date Range of Records (From - To):

5. Purpose of Disclosure

Specify the reason for this release (e.g., "Personal Use", "Legal Claim", "Continuing Care", "Insurance Transfer"):

6. Authorization Period & Expiration

This authorization will automatically expire one year from the date of signature unless otherwise specified below:

Specific Expiration Date or Event:

7. Acknowledgement and Signature

By signing below, I understand that I may revoke this authorization at any time by providing written notice. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations.

Signature of Patient or Legal Representative: _____

Date Signed: _____

If Legal Representative, state relationship to patient: _____