

Patient Health Information Release Authorization

Please complete all sections of this form to authorize the disclosure of your protected health information. This form is designed to be filled out and printed.

1. Patient Information

Full Name:

Date of Birth (MM/DD/YYYY):

Phone Number:

Email Address:

Street Address:

City, State, Zip Code:

2. Entity Authorizing to Release Information (From)

Organization/Provider Name:

Address:

Phone Number:

Fax Number:

3. Recipient of Released Information (To)

Recipient Name / Organization:

Address:

Phone Number:

Fax Number:

4. Information to be Released

Specify the health information you authorize to be released (Type "Yes" or details next to the items):

Complete Medical Record (Type Yes/No):

Specific Dates of Service (Specify dates):

Laboratory / Pathology Reports (Type Yes/No):

Imaging / X-Ray Reports (Type Yes/No):

Billing Records (Type Yes/No):

Other Specific Information (Please describe):

5. Purpose of Disclosure

Purpose (e.g., Personal Use, Continuation of Care, Legal, Insurance):

6. Expiration and Revocation

This authorization will expire on (Date or Event):

I understand that I have the right to revoke this authorization at any time by providing written notice to the releasing entity. I understand that the revocation will not apply to information that has already been released in response to this authorization.

7. Signatures

By signing below, I authorize the release of my health information as described above.

Signature of Patient or Legal Representative (Print name to sign digitally, or sign physical printout):

Date (MM/DD/YYYY):

Relationship to Patient (if signed by Legal Representative):