

# Third Party Medical Information Disclosure Form

Please complete all sections of this form to authorize the disclosure of your protected health information to a third party. This form is designed to be printed and filled out or completed digitally before printing.

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## 1. Patient Information

Patient Full Name:

Date of Birth (MM/DD/YYYY):

Phone Number:

Email Address:

Street Address:

City, State, Zip:

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## 2. Authorized Third Party (Recipient)

Identify the individual or organization authorized to receive the medical information.

Name of Person or Organization:

Relationship to Patient:

Phone Number:

Street Address:

City, State, Zip:

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## 3. Scope of Information to Disclose

Specify the medical information you authorize to be released (e.g., "All records," "Lab results from Jan 2023," "Progress notes").

Description of Medical Information:

Purpose of Disclosure (e.g., Personal Use, Legal, Continuity of Care):

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## 4. Expiration of Authorization

This authorization will expire on the date or event specified below. If no date is specified, this authorization will expire one year from the date of signature.

Expiration Date or Event:

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## 5. Acknowledgment and Signature

By signing below, I authorize the disclosure of my protected health information as described above. I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken.

Signature of Patient or Legal Representative:  Date:

If Legal Representative, State Relationship: