AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: **Date of Birth** **Tel Number**

I REQUEST AND AUTHORIZE TO RELEASE MEDICAL RECORD INFORMATION CONCERNING THE ABOVE-MENTIONED PATIENT.

FROM:	**TO:**
Name or Facility	Name or Facility
Address	Address
Tel # Fax #	Tel # Fax #

THIS REQUEST AND AUTHORIZATION APPLIES TO:

❍ All healthcare information.

❍ Healthcare information relating to the following treatment, condition, and/or dates:_____

❍ Other_____

Patient or Legal Representative Signature Date

Printed Name if Signed by Legal Representative Relationship to Patient

This authorization expires in 60 days from the date of request. Please allow five 5 – 10 business days for completion.

NOTE: There is no charge when healthcare information is sent directly to a medical provider for the continuation of care. A processing fee, however is charged if a copy of health care information is requested by the patient, parent(s) or authorized representative.