

# PATIENT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

## SECTION A

Name: \_\_\_\_\_ #: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Fax: \_\_\_\_\_  
E-mail: \_\_\_\_\_

## SECTION B

I am requesting the following information:

- All information ( )
- Information regarding ( )
- All information ( )

## SECTION C

Please release information to:

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Fax: \_\_\_\_\_  
E-mail: \_\_\_\_\_

If I am not the patient, I will be charged \$.12 a page for copying

**SECTION D To be READ AND INITIALED by patient/patient's representative. THIS SECTION MUST BE COMPLETED.**  
This authorization/consent will expire when acted upon or 90 days from the signed date, whichever occurs first.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_