

Authorization for Release of Health Information

Release Records To: _____

Address: _____

Phone: _____ Fax: _____

Release Records From: _____

Address: _____

Phone: _____ Fax: _____

I hereby authorize the release of records on the following patients:

Patient's Name: _____ Date of Birth: _____

Patient's Name: _____ Date of Birth: _____

Patient's Name: _____ Date of Birth: _____

Patient's Name: _____ Date of Birth: _____

The information to be included for use and/or disclosure (Check One):

Complete medical record
 Portions of the record as specified below _____

The information will be used or disclosed for the following purpose (Check One):

Transfer medical record to another physician
 Other (please specify) _____

By signing below, I, as the parent/guardian, authorize the records release of the patient(s) indicated above. I understand that I may revoke this authorization at any time and that unless a previous date is specified it will automatically expire 12 months from the date this form is signed.

Printed Name: _____

Signature: _____ Date: _____

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