[Doctor Name]
[Doctor Name]
[Doctor Name]
[Doctor Name]
[Doctor Name]
[Doctor Name]
[Doctor Name]

YOUR LOGO HERE

[Street Address], [City, ST ZIP Code]
Phone: [Phone Number] Fax: [Fax Number]

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

This Authorization will remain in effect:

☐ From the date of this authorization until:_____

☐ Until the following event occurs:_____

Unless otherwise noted above this authorization will remain in effect 180 days from the date signed.

Signature of Patient or Legal Representative: _____ Date: _____