Personal Medical Information Release Form

By signing this form, I, ___________________________ (patient's name) authorize you to release confidential health information about me, by releasing a copy of my medical records, history, or a summary or narrative of my Protected Health Information, to the person(s) or entity listed below.

Limitations on the information you may release subject to this Release Form are as follows:

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Information or medical history I would not like released are as follows:

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The above medical information shall only be released to the following persons/entity:

Family Member/Personal Representative/Entity	Relationship:
Name: ______________________	Relation: ______________________
Address: ______________________	Information witheld:
City/State/Zip: ______________________	______________________
	______________________
Name: ______________________	Relation: ______________________
Address: ______________________	Information witheld:
City/State/Zip: ______________________	______________________
	______________________
Name: ______________________	Relation: ______________________
Address: ______________________	Information witheld:
City/State/Zip: ______________________	______________________
	______________________

The reasons of purposes for this release of information are as follows:

____

I know that I am entitled to receive a copy of this Release Form.

Name____

Signature ____

Signed this ______________________day of __________ 20__________

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