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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: _____

Date of Birth: _____

I request and authorize:

Dr. _____

Phone: _____Fax:_____

To release my medical information to:

Name: _____

Phone: _____Fax:_____

I understand that my health records are protected under both Federal and State confidential regulations, and cannot be disclosed without my written consent, unless otherwise provided for in those regulations. I understand that I have the right to withdraw this authorization at any time except for action already taken, and that such revocation must also be in writing. Further, I understand that this authorization without prior revocation will automatically expire 90 days from the date of my signature.

This Request and Authorization applies to:

_____ **Healthcare information relating to the following specific treatment, condition, or dates of treatment:**_____

_____ **Other:** _____

Signature: _____ **Date:** _____

Relationship, if signed by anyone other than the patient: _____