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Authorization to Release Healthcare Information

Patient Name: ________________________________ Date of Birth: _______________

Previous Name:_______________________________ Social Security #:____________

I request and authorize ________________________________or his office staff to release healthcare information for the above to:

Name: ______________________________ Phone: _______________________

Address: ______________________________ Fax: _________________________

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This request and authorization applies to:

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

☐ Progress Notes ☐ Operative Reports
☐ Other (please specify) ____

☐ Lab Reports ☐ Special Studies (EMG, MRI, etc.)
☐ Other: ____

For the purpose of: ☐ Continuity of Medical Care ☐ Legal ☐ Insurance
☐ Other (please specify): _____________________

I understand that this authorization is valid for 90 days from the date of my signature. I understand that this authorization authorizes the release of all my medical records. I further understand that I can revoke this authorization in writing at any time prior to the expiration date. In addition, I understand that any release of this information by the recipient without my further consent is prohibited. Finally, I understand that a photocopy of this authorization may be considered valid.

Patient signature: ____________________________Date signed: __________________

This authorization expires ninety days after executed.