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Authorization for Release of Protected Health Information

Patient Name: _____ Patient Date of Birth: _____

The person named above has been a patient of:

Name of Medical Provider:
Address of Medical Provider:
Phone:
Fax:

The person or parent named above hereby authorizes _____ to release the medical records to the following:

Name of Medical Provider:
Address of Medical Provider:
Phone:
Fax:

Scope of Release (please place an X on one)

- o Complete medical record
- o All information regarding assessment, diagnosis, and treatment of the patient's condition, concern, or disease
- o Other (please specify): _____

I understand that this authorization is effective for a period of one year from the signature date unless otherwise specified. I understand I have the right to revoke this authorization at any time by sending a written request to the entity I authorized to release the information. By signing this authorization, you are agreeing to the use and disclosure of certain protected health information to the recipient listed above.

Authorization:

Name of Authorized Representative (Print):		
Signature:	Date:	Initial:

If not signed by the patient because the patient is a minor, please indicate the relationship of the person authorizing this form: _____