

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____

Address: _____

Date Of Birth: _____ **Social Security Number:** _____

I hereby authorize _____ to release the following medical information to:

Name of person/facility: _____

Address: _____

Please include the following:

- | | | | |
|--------------------------------------|--|--|--|
| <input type="checkbox"/> All Records | <input type="checkbox"/> History | <input type="checkbox"/> Physical | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Lab Reports | <input type="checkbox"/> X-rays/MRI | <input type="checkbox"/> Care Plan | <input type="checkbox"/> Operative Reports |
| <input type="checkbox"/> EKG Report | <input type="checkbox"/> Therapy Reports | <input type="checkbox"/> Psychological Reports | |
| <input type="checkbox"/> Other _____ | | | |

Please exclude the following specified information: _____

This authorization covers care provided from _____ to _____

Purpose of disclosure: Medical Care Employer Insurance
 Attorney Other _____

This authorization is valid for 120 days from the date of signature. Consent for authorization may be revoked at any time prior to the expiration date except to extend that disclosure made in good faith has already occurred in reliance on this consent.

Signed: _____ **Date:** _____
 Patient or Representative

Relation to Patient

Witness