

# AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

TO REQUEST RELEASE OF MEDICAL INFORMATION PLEASE COMPLETE AND SIGN THIS FORM

I, \_\_\_\_\_ hereby voluntarily authorize the disclosure of information from my health record.  
(Name of Patient)

**Patient Information:**

Patient Name: \_\_\_\_\_ Record Number: \_\_\_\_\_

Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Information Requested:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Purpose of Release:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**The Information Is To Be Provided To:**

Name of Person/Organization/Facility: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

\_\_\_\_\_  
Patient's Signature or Patient's Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient's Representative

\_\_\_\_\_  
Relationship of Patient

**This information is to be released for the purpose stated above and may not be used by recipient for any other purpose.**

**PLEASE MAKE A COPY OF THIS RELEASE FOR YOUR RECORDS**

**HIPAA Authorization For Release of Medical Records**