Authorization to Release Health Care Information

Patient's name: _____ Date of birth: _____

SSN: _____ Previous name: _____

I request and authorize _____ to release health care information of

the patient named above to:

Name: _____ _____
Institutional Affiliation

Address: _____

City, State: _____ Zip Code: _____

This request and authorization applies to:

_____ Health care information relating to the following treatment, condition, or dates of treatment:

_____

_____ All health care information

_____ Other: _____

_____
Signature of patient or patient's authorized representative date signed

_____
Relationship or status if signed by anyone other than patient (parent, legal guardian, personal representative, etc.)

THIS AUTHORIZATION EXPIRES 90 DAYS AFTER THE DATE IT IS SIGNED 03/08