



AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name _____ Date of Birth _____

Previous Name _____ Social Security # _____

I request and authorize _____ to
release healthcare information of the patient named above to:

Name _____

Address _____

City _____ State _____ Zip Code _____

This request and authorization applies to:

Healthcare information relating to the following treatment, condition, or dates: _____

All healthcare information

Other: _____

Patient Signature _____ Date _____

THIS AUTHORIZATION IS VALID FOR ONE YEAR