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## Authorization of Medical Release of Medical Information

Attention:

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Patient's Name:

Date of Birth:

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I, \_\_\_\_\_, request and authorize \_\_\_\_\_ to release the healthcare information of the patient listed above to:

Provider/Facility Name:

Address:

Contact Number:

Fax Number:

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This request and authorization applies to:

Healthcare information related to the following treatment, condition or dates:

\_\_\_\_\_

All Healthcare Information

Other: \_\_\_\_\_

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I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for twelve (12) months from the date of the signature. I understand that I may cancel with written notification, but that it will not affect any information released prior to notification of the cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished may not condition their treatment of me on whether or not I sign this authorization.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_