

AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION

I authorize you to release the specific information described below, only for the purpose and parties described below:

Name Of Patient_____	Date of Birth_____	
Social Security Number_____		
Patient's Address_____		
(Address-Street)		
(City)_____	(State)_____	(Zip Code)_____

Name and Address of Party To Whom Information Is To Be Released:

Type of information to be disclosed:

- Complete Medical Record
- Last Visit
- Other (please describe)_____

This information is being requested for the following purposes:

This authorization shall remain in effect from the date signed below until_____.
(expiration date or event)

Signature of Patient, Parent of a Minor,
Legal Guardian or Personal Representative*

Date

Relationship To Patient

*If legal Guardian or Personal Representative, a copy of the Letters of Authority is necessary