

**AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION**

Patient's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

**I request and authorize:**

Name: \_\_\_\_\_

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

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**To release health care information of the patient named above to:**

Name: \_\_\_\_\_

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

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

This request and authorization applies to:

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

\_\_\_\_\_

All health care information

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

Patient Signature: \_\_\_\_\_

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

*This authorization expires ninety days after it is signed.*