Authorization to Release Medical Information

Patient Name: _____

Address: _____

Phone Number: _____ Email: _____

Birthdate: _____ Social Security Number: _____

Other Aliases: _____

Name of Guardian or Legal Representative: _____

Address: _____

Phone Number: _____ Email: _____

I hereby authorize the following health care professional, medical facility, mental health facility, laboratory, paramedical facility, medical examiner, medical records service, prescription clearinghouse, consumer reporting agency, employer, or family member to release (Check One) __ all health information about me __ my medical records as described on the following page:

Person / Organization to Release Information: _____

Street Address: _____

City: _____ State: _____ ZIP Code: _____

Phone Number: _____ Fax Number: _____

Patient Signature: _____