Reset

# AUTHORIZATION TO RELEASE INFORMATION

Patient Name: _____

Patient Address: _____

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Date of Birth:

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I hereby authorize this practice to release my medical records to the indicated address below.

The information is to be disclosed to:

Name of Entity: _____

Attention: _____

Address: _____

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Description of information to be disclosed: _____

Reason for requested use or disclosure:

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Please understand that there may be a charge for copies of x-rays and/or any other medical information that you have requested to be sent.

Patient Signature: _____

Signature of Patient's Representative/ Relationship:

_____

Date: _____

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