# AUTHORIZATION TO RELEASE MEDICAL INFORMATION

| Name of Patient | | Date of Birth |
|---|---|---|
| Other Aliases | | |
| Street Address | | |
| City | State | Zip |
| Phone Number<br>(  ) | Email Address | |

I hereby authorize the following health care professional **to release** all health information about me:

| Health Care Professional/Organization to RELEASE Information | | |
|---|---|---|
| Street Address | | |
| City | State | Zip |
| Phone Number<br>(  ) | Fax Number<br>(  ) | |

The following person/organization is hereby authorized **to receive** my entire medical record, treatment record, and diagnostic record:

| Person/Organization to RECEIVE Information | | |
|---|---|---|
| Street Address | | |
| City | State | Zip |
| Phone Number<br>(  ) | Fax Number<br>(  ) | |

_____ _____

Patient or Legal Guardian Signature Date