AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____ Date of Birth: _____

Records to be Sent To:

Facility / Provider Name: _____

Address: _____

City/State/ZIP: _____

Phone: _____ Fax: _____

Description of Information to Be Released (check at least one)

☐ All medical records on file ☐ Most recent records only

☐ Testing ☐ Therapy / Rehabilitation records

☐ Billing records ☐ Other:

_____

Method of Delivery

☐ Fax ☐ Mail ☐ Secure Email (if available)

I authorize the above-named practice to release the information described above to the facility/provider listed on this form.

Patient / Legal Guardian Signature: _____

Printed Name: _____

Relationship to Patient (if applicable): _____

Date: _____

Patient Rights & Acknowledgements

I understand that I may revoke this authorization in writing at any time before the records are released. I understand that information disclosed may be subject to re-disclosure by the recipient. I understand that treatment is not conditioned on signing this authorization.

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