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****Authorization for Release of Patient Health Information****

Patient Information
Name: _____ Date of Birth: _____
Address: _____
Phone Number: _____ Email: _____

Release From:
_____
_____
_____
_____
I hereby authorize to release my medical records as described below:

Records to be Released
From: [Start Date] _____ To: [End Date] _____
□ Medical Summary □ Laboratory Reports □ Imaging Reports □ Prescription Information □ Other:

Purpose of the Release
□ Continuity of Care □ Personal Use □ Legal □ Insurance □ Other: _____

Method of Delivery (check one)
□ Mail □ Fax □ Email □ Patient Pick-Up
□ Other: _____

Patient Rights
I understand that I have the right to revoke this authorization at any time by providing written notice to [Practice Name/Hospital Name]. I am aware that the revocation will not apply to information that has already been released in response to this authorization. I understand that the information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations.

Patient / Guardian Signature: _____ Date: _____