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Authorization for Release of Medical Information

PATIENT'S NAME_____DOB:_____

CELL PHONE:_____E-MAIL:_____

I hereby authorize_____, its Director or designee, to release information contained in the medical records of the patient identified above in according with Federal Regulation and/or communication made by me.

1. NAME AND ADDRESS TO WHOM THE INFORMATION IS TO BE DISCLOSED

_____

2. SPECIFIC INFORMATION TO BE DISCLOSED

   __ ENTIRE MEDICAL RECORD

   __ PARTIAL MEDICAL RECORD_____

   _____

   _____

3. PURPOSE AND NEED FOR SUCH DISCLOSURE:

   _____

4. This consent is a subject to revocation at any time expect
5. Without expressed revocation, this consent expires 90 days subsequent to signing, or on the date set forth below, or for the following specific reasons

   DATE:_____ OR EVENT:_____

   CONDITION:_____

   NOTE: A COPY OF THIS AUTHORIZATION IS VALID AS ORIGINAL

Signature of Patient/Legal Representative: _____DATE:_____