Medical Records Release Authorization

By signing this form, I authorize you to release confidential health information for:

Patient Name: _____ Date of Birth: _____

You may disclose this medical record information to:

Name: _____

Address: _____

City/State/Zip: _____

Phone: _____ Email: _____

This authorization is valid for thirty (30) days from the date of signing and may be revoked at any time by providing written notice of revocation. I understand I cannot revoke this authorization retroactively for information already released.

_____ _____

Signature of patient or legally authorized individual Date

_____ _____

Printed Name Relationship (parent, legal guardian)

_____

Phone Number

_____

Email