Authorization to Release Information Form

Patient information	
Name: Esmeralda Connors	**Gender:** Prefer not to say
Date of birth: March 19, 1991	**Social security number:** 8924-1234
Address: 56 Harold St CA	
Phone number: e@connors@gmail.com	**Email:** 789-491-2
Healthcare provider information	
I, Esmeralda Connors, authorize the following entity to release my information:	
Name/organization: Jennifer Lee, MD	
Address: Harold Hospital 50 Harold St CA	
Phone number: 789-00-000	**Email:** jeniffer@haroldhospital.org
Recipient information	
I, Esmeralda Connors, authorize the release of my information to the following entity:	
Name/organization: Michael Yu	
Address: Peters Hospital 65 Mary St CA	
Phone number: 090-135-22	**Email:** michael@peters.com
Information to be released	
The information to be released includes (check all that apply):	
☐ Discharge summary ☑ Laboratory test results ☐ Nurse notes ☐ Entire medical record ☐ Physician's orders	☐ X-ray report ☐ Pathology report ☐ Progress notes ☐ History and physical report ☐ Other (please specify):

Purpose of release

The information is being released for the following purpose(s):

☐ Continuing care	☐ Academic
☐ Legal purposes	☐ Employment
☐ Personal use	☐ Other (please specify):
☐ Insurance	

Expiration of authorization

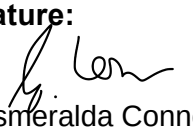
This authorization will expire on December 12, 2024 or upon the occurrence of the following event: N/A

Revocation of authorization

I, Esmeralda Connors, understand that I have the right to revoke this authorization at any time by providing a written notice to the entity releasing the information. The revocation will not affect any information that has already been released prior to the receipt of the revocation.

Acknowledgment

I have read and understand the terms of this authorization. By signing below, I authorize the release of my information as specified above.

Name and signature:  Esmeralda Connors	**Date:** August 6, 2024
Witness' name and signature:  Allison Meyer	**Date:** August 6, 2024