Authorization to Release Information Form

Patient information	
Name:	**Gender:**
Date of birth:	**Social security number:**
Address:	
Phone number:	**Email:**
Healthcare provider information	
I, _____[Patient name]_____, authorize the following entity to release my information:	
Name/organization:	
Address:	
Phone number:	**Email:**
Recipient information	
I, _____[Patient name]_____, authorize the release of my information to the following entity:	
Name/organization:	
Address:	
Phone number:	**Email:**
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 ☐ Legal purposes ☐ Personal use ☐ Insurance	☐ Academic ☐ Employment ☐ Other (please specify):
Expiration of authorization	
This authorization will expire on _____[Date]_____ or upon the occurrence of the following event:	
Revocation of authorization	
I, _____[Patient name]_____, 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: [Name]	**Date:**
Witness' name and signature: [Name]	**Date:**