AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

_____
Date

To: _____ Fax: _____

_____ _____
Patient Name Date of Birth

_____
Address

_____
City, State, Zip

I, _____, hereby authorize _____ to ☐ receive or ☐ disclose information from the above named patient's medical records, including laboratory results, radiologic testing results, medications, hospitalization information, office notes, and treatment plans for the purposes of _____ _____. I understand that this authorization will expire in 30 days, and that it may be revoked at any time in writing. I further understand that continued treatment of the above named patient is not contingent upon receipt of this information. Also, the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by the HIPAA privacy rule.

Please send the requested information to:

_____
Name

_____
Address

_____
City State Zip

_____
Phone

_____
Fax

Specific records being requested:

_____

_____

_____

_____

Signature of Patient or Legal Guardian	Relationship