Authorization for Release of Medical Information

The **Authorization for Release of Medical Information** form sample is a crucial document that allows patients to grant permission for their health records to be shared with specified parties. This form ensures compliance with privacy laws while facilitating communication between healthcare providers and third parties. It streamlines the process of obtaining and disclosing medical information securely and efficiently.

Sample Form

Patient Information

Patient Name:

Date of Birth:

Address:

Recipient Information

Name/Organization to Receive Information:

Recipient Address:

Information to be Released

Type(s) of Information:

- [ ] Medical History
- [ ] Diagnosis
- [ ] Lab Results
- [ ] Other

Purpose of Disclosure:

Authorization & Signature

I hereby authorize the release of my medical information as specified above:

Patient/Guardian Signature:

Date:

- [ ] I understand that I may revoke this authorization at any time in writing.

Submit