Patient Authorization Request Form Sample

The **Patient Authorization Request Form** sample is designed to streamline the process of obtaining consent for medical information release. This form ensures compliance with privacy regulations while facilitating efficient communication between healthcare providers and patients. Using a clear and standardized format, it helps protect patient rights and supports seamless administrative workflows.

Patient Information

Full Name:

Date of Birth:

Address:

Phone Number:

Email:

Authorization Details

Healthcare Provider/Facility:

Information to be Released:

Purpose of Release:

Expiration Date of Authorization:

Patient Consent

☐ I hereby authorize the release of my medical information as described above. I understand that this authorization is voluntary and that I may revoke it in writing at any time.

Signature

Signature:

Date:

Submit Authorization