Medical Release Authorization Form Sample

The **Medical Release Authorization Form Sample** is a crucial document that grants permission for the disclosure of an individual's medical information. It ensures compliance with privacy laws while facilitating communication between healthcare providers and authorized parties. Using this form streamlines the process of sharing sensitive health data securely and efficiently.

Medical Release Authorization Form

Patient Information

Full Name:

Date of Birth:

Address:

Recipient Information

Name of Person/Organization:

Address:

Authorization Details

Type of Information to be Disclosed:

- ☐ Medical History
- ☐ Lab Results
- ☐ Imaging Reports
- ☐ Other (Specify):

Purpose of Disclosure:

Authorization Period

Start Date:

End Date:

☐ I understand that I may revoke this authorization at any time in writing, except to the extent that action has already been taken.

Patient Signature:

Date Signed:

Submit