Authorization to Release Medical Information Form Sample

The **Authorization to Release Medical Information Form** sample provides a clear template for granting permission to share personal health data. It ensures compliance with privacy laws while facilitating efficient communication between healthcare providers and authorized parties. This form is essential for protecting patient rights and maintaining confidentiality during the information exchange process.

Sample Authorization to Release Medical Information Form

Patient Information

Full Name:

Date of Birth:

Address:

Phone Number:

Recipient Information

Name or Organization:

Address:

Medical Information to be Released

- [ ] All Medical Records
- [ ] Specific Records (please specify): e.g., lab results, X-rays

Purpose of Release

e.g., continuing care, insur

Authorization Duration

This authorization expires on:

- [ ] I understand that I may revoke this authorization at any time in writing and that information released may no longer be protected by federal privacy law.

Signature of Patient/Representative:

Date:

Submit