Patient Information Release Authorization Form Sample

The **patient information release authorization form sample** is a crucial document that allows healthcare providers to share a patient's medical records with authorized parties. This form ensures compliance with privacy laws while facilitating smooth communication between medical professionals and patients. Using a well-structured sample helps streamline the process of obtaining consent efficiently.

Patient Information Release Authorization Form

Patient Name:

Date of Birth:

Address:

Phone Number:

Release Information To (Name/Organization):

Purpose of Information Release:

Information to be Released:

- [ ] All Medical Records
- [ ] Lab Reports
- [ ] Imaging Results
- [ ] Other (specify below)

Specify other information

Authorization Expiration Date:

- [ ] I authorize the release of my health information as indicated above.

I understand that this authorization is voluntary and that I may revoke it at any time.

Patient's Signature:

Date Signed:

Submit