Third Party Authorization Form for Medical Records

This **third party authorization form sample** for medical records allows patients to grant permission to another individual or organization to access their health information securely. It ensures compliance with privacy laws while facilitating the transfer of medical data. Using a standardized form helps streamline communication between healthcare providers and authorized parties.

Patient Information

Full Name:

Date of Birth:

Address:

Phone Number:

Authorized Third Party Information

Name/Organization:

Relationship to Patient:

Address:

Phone Number:

Information to be Disclosed

- [ ] All medical records
- [ ] Specific records (please specify):

Purpose of Disclosure

e.g., Insurance, second op

Authorization & Signature

I hereby authorize the release of my medical information as described above.

Patient Signature:

Date:

Note: This authorization is valid for one year from the date signed unless otherwise specified. You may revoke this authorization at any time by submitting a written request to your healthcare provider.

Submit