Practice Name

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, _____
(Patient's name)

D.O.B. _____ LAST FOUR OF SS# _____

_____

GIVE: _____

_____

_____

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION REGARDING MY MEDICAL STATUS TO (ORGANIZATION/PERSON(S)):

_____
_____
_____
_____
(Name)
_____
(Address) (Phone)

THE FOLLOWING TYPES OF INFORMATION ARE SPECIALLY AUTHORIZED FOR RELEASE:

_____

_____

_____

EXPIRATION DATE OF THIS AUTHORIZATION: _____/_____/_____

_____ _____
(Patient's signature) (Date)

_____ _____
(Witness signature) (Date)

Our Notice of Privacy Practices provides information about our use of a patient's protected health information (PHI). The Notice contains a Patient Rights section describing your rights under the law. Patients have the right to access, inspect, and copy protected health care information used to make decisions about them.