Patient Authorization for Disclosure of Health Information

Patient Information

Full Name

Date of Birth

Phone

Address

Recipient

Name/Organization

Phone or Fax

Address

Information to be Disclosed

Type(s) of information (e.g., labs, notes, imaging, other â€“ specify):

Date(s) of Service (if applicable):

Purpose of Disclosure

Authorization & Signature

I understand that this authorization is voluntary. I may revoke this authorization at any time in writing. I understand that once the information is disclosed, it may be subject to redisclosure and may no longer be protected.

Patient/Representative Signature

Date

If signed by Representative: Relationship/Authority

Note: This authorization will expire one year from the date of signature unless otherwise specified here: