SELECT
INTERNAL MEDICINE &
PEDIATRICS

Authorization to Release Healthcare Information

Patient Name: _____ DOB: _____

I request and authorize:

Doctor's/Clinic Name: _____
Address: _____
_____

Phone #: _____
Fax #: _____

To release healthcare information of the patient named above to:

Doctor's/Clinic Name: _____
Address: _____
_____

Phone #: _____
Fax #: _____

☐ Healthcare information relating to the following treatment, condition or dates:

_____

☐ All healthcare information

☐ Other: _____

Patient/Guardian Signature: _____

Date: _____

* This authorization expires ninety days after it is signed *