

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient name:

Date of birth:

Street address:

City, State Zip:

Phone number:

Email:

I request and authorize healthcare information to be sent **FROM:**

Clinic or provider:

Provider address:

City, State Zip:

Clinic phone:

Clinic fax:

Email:

TO:

Clinic or provider:

Provider address:

City, State Zip:

Clinic phone:

Clinic fax:

Email:

This request and authorization applies to:

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

All healthcare information

Other:

Patient signature:

Date signed: