Patient Record Release

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Authorization for Use or Disclosure of Protected Health Information

I hereby voluntarily authorize the disclosure of information from my health record. I understand that I may revoke this authorization at any time in writing and submitted to the covered entity above, except to the extent that action has been taken in reliance on this authorization.

First & Last Name *

Date

Signature *

Sign above

The information from my health record is to be disclosed by the covered entity above and provided to the following:

Name of Person/Organization

Contact Number

(___) ___-____

Address

City

State

Zip

Office Email Address

The information to be disclosed from my health record is limited to (check):

- ☐ Only information related to:
- ☐ Only for the period from: to
- ☐ Entire health record