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**AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION**

Patient's name \_\_\_\_\_ Date of birth \_\_\_\_\_

Previous name \_\_\_\_\_ Social security # \_\_\_\_\_

I request and authorize \_\_\_\_\_

Phone # \_\_\_\_\_ fax # \_\_\_\_\_

To release healthcare information of the patient named above to:

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone# \_\_\_\_\_ Fax# \_\_\_\_\_

This request and authorization applies to:

\_\_\_ All healthcare information \_\_\_ Specific date or treatment \_\_\_\_\_  
(list date or treatment)

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_