AUTHORIZATION TO RELEASE MEDICAL INFORMATION

(The execution of this form does not authorize the release of information other than that specifically described below)

Individual granting release of medical records: (Type or print)

☐ **Patient (Self)**	☐ **Parent or Authorized Legal Guardian** **Name: _____**

Patient Information

Name: _____ S.S.No: _____ DOB: _____

Address: _____

Information Requested	Date range may be specified if applicable: _____ ☐ Copy of complete medical records/notes ☐ Copy of medical records pertaining only to: _____

RELEASE MEDICAL RECORDS TO REQUESTOR
(Select one – A separate release must be completed for multiple recipients)

☑ **Physician or Health Care Facility**	Name: _____ _____ Address: _____ _____
☐ **Law firm, Attorney or Agency**	Name: _____ Address: _____ _____
☑ **Consultation Physical Therapist or other medical professional**	Name: _____ Address: _____ _____
☑ **Individual**	Name: _____ Address: _____ _____

I, _____ specifically authorize _____

_____ to release medical records to the requestor named above.

_____ _____

Authorized Signature (Patient or legal guardian Date