

AUTHORIZATION FOR RELEASE OF RECORDS

_____ (Name of Hospital)

Patient Name and Address: _____

Social Security No: _____

Birth Date: _____

I, the undersigned, authorize _____ (Name of Hospital)

to furnish medical information concerning the above-named patient to the following persons and institutions: _____

_____ (Names and Mailing Addresses of Persons or Institutions Requesting Information).

This medical information is to be limited to the following: _____

_____ (Specify Such Information as Medical Condition or Injury; Treatment, Examination, or Hospitalization Received; and Dates of Treatment).

The above-named persons and institutions may use the information authorized only for the following purposes: _____

_____ (Specify).

The further use or disclosure of the authorized information by the above-named persons and institutions may not be accomplished without my further written consent.

This authorization shall become effective immediately and shall be valid until _____ (Date), unless expressly revoked by me.

Signature of patient or Authorized Person Date

Relationship to Patient

Witness Date