AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Name of Patient	
Address	
Phone Number	E-mail
Birthdate	Social Security Number
Other Aliases	

Name of Guardian or Legal Representative	
Address	
Phone Number	E-mail

I hereby authorize the following health care professional,medical facility, mental health facility, laboratory, paramedical facility, medical examiner, medical records service, prescription history clearing house, employer, or family member to release (Check one)

- ☐ all health information about me
- ☐ my medical records as described on the following page:

Person/Organization to Release Information	
Street Address	
City	State
Phone Number	Fax Number