

# PATIENT HEALTH INFORMATION RELEASE FORM

## I HEREBY AUTHORIZE:

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## TO RELEASE TO:

**Physician:**

**Self:**

Name

Name

Address

Address

Phone

Fax

Phone

Fax

Fax

Fax

Mail

Mail

Pick Up

## RECORDS AND INFORMATION OF:

PATIENT NAME: \_\_\_\_\_ D.O.B: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

All Records

From:

To:

Specific \_\_\_\_\_

Visit Date

Date Range \_\_\_\_\_

Pertaining to: \_\_\_\_\_

**Duration:** I understand that this authorization is effective immediately and shall be valid for one year or until the date entered here: \_\_\_\_\_

**Right to Revoke:** I understand that I may revoke this authorization in writing at any time.

**Reuse:** I understand that no other use will be made of this information without prior authorization from me unless such use is specifically required/permitted by law.

**\*Please allow 48 to 72 hours for processing from the time of receipt.**

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

Physician Signature \_\_\_\_\_ Date: \_\_\_\_\_