REQUEST FOR DISCLOSURE OF PERSONAL HEALTH INFORMATION

I, hereby authorize _____
(name of facility releasing information)

to release the following information
_____
_____
_____

to _____
(name and address of person/agency to whom the information is to be disclosed)

from the records of _____ _____
(legal name of patient) (date of birth)

concerning treatment on _____
(date(s) of contact/hospitalization)

I understand that this information is to be used by the recipient for the purpose of
_____
_____

Date: _____ Signed by: _____

Signature of Witness: _____ _____
(relationship if signed by other than patient)

This information is valid for three months from the date of signing. It may be rescinded or amended in writing at any time prior to that date, except where action has been taken in reliance on the authorization.

Office Use Only: Verification of identity of individual consenting to the disclosure:

Form of ID: ___Drivers License ____ Passport _____ Notarized/Lawyer's Letter ___Other

ID Checked by: _____ _____
Printed Name Signature