



AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

I hereby authorize _____ to release the following information:
(Name of facility releasing information)

(Description of information to be disclosed)

to _____
(Name and address of person/agency requesting information)

from the records of _____
(Name of Patient) _____
(Date of Birth, YY/MM/DD)

(Address of Patient)

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

(Description of Purpose)

I DECLARE THAT I HAVE READ THIS RELEASE OR IT HAS BEEN READ OR EXPLAINED TO ME AND THAT I FULLY UNDERSTAND IT.

DATE: _____ **SIGNATURE:** _____
(Y/MM/DD) *(Signature of Patient or Substitute Decision Maker)*

DATE: _____ **SIGNATURE:** _____
(YY/MM/DD) *(Witness to Signature)*

NOTE: THIS AUTHORIZATION MUST CONTAIN ORIGINAL SIGNATURES

Please Note: This Authorization For Release of Information is valid for 6 months and pertains to the disclosure of information that is specific to treatment received on or before the date signed. It can be amended or withdrawn at any time by written notification to the hospital.