This is a sample form to assist you in creating a unique form that addresses the specific circumstances of your practice.

Sample Patient Authorization to Release Medical Information

Patient Name (Print)	Medical Reference Number	Patient DOB
I authorize (practice/physic	ian's name) to use or release/disclose my health information	n as described below.
Please identify the information to be Please release my entire rec		
-OR-		
-	owing information (check appropriate boxes and include oth	her information where indicated):
Problem list Noticetion list		
Medication listList of allergies		
\square Immunization records		
$\square Most recent history and$	l physical	
☐ Most recent discharge s		
□ Lab results (please deso	cribe the dates or types of lab tests you would like disclosed	l):
\Box X-ray and imaging repo	orts (please describe the dates or types of x-rays or images y	you would like disclosed):
	lease supply doctors' names):	
□ Other (please describe)		
This disclosure and use is for the fo	ollowing purpose(s):	
(Note: The statement "at the reque not, or chooses not to, state the pu	est of the individual" is sufficient when the individual in rpose.)	itiates an Authorization and does
	rpose.)	itiates an Authorization and does
not, or chooses not to, state the pur Please initial each item below to indi I understand the information acquired immunodeficiency	rpose.)	exually transmitted disease(s), V). It may also include information
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