AUTHORIZATION TO RELEASE PATIENT MEDICAL INFORMATION

PATIENT INFORMATION

Subscriber Name: _____ Acct. #: _____

Former Name (if any): _____ SS #: _____

Daytime Telephone: (___)_____ Birth Date: _____

INFORMATION TO BE RELEASED TO:

I hereby authorize the following person(s) access to my medical information contained in my medical/claim records.

_____	_____	_____
Name of Person(s)	Date of Birth	Password
_____	_____	_____
Name of Person(s)	Date of Birth	Password

Purpose or need for this information is:

_____

_____

_____

_____

PATIENT AUTHORIZATION TO RELEASE MEDICAL INFORMATION

_____ _____

Patient's Signature Date

_____ _____

Parent or Legal Guardian (if patient is under age 18) Date