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AUTHORIZATION TO RELEASE/REQUEST HEALTHCARE INFORMATION

Patient's Name: Date of Birth:

Patient's Name: Date of Birth:

I hereby authorize the use or disclosure of my health information **FROM**:

Name of Practice:

Address:

Phone Number:

Fax Number:

To release my health information **TO:**

Name of Practice:

Address:

Phone Number:

Fax Number:

This request and authorization applies to:

☐ Immunization Records ☐ Laboratory & X-Ray Reports

☐ Growth Chart & Chart Notes ☐ Entire Medical Records

Patient Signature: _____ Date Signed: _____