

# Authorization to Release Information to a Health Care Provider

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**Patient Information:**

Name of Patient \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

**Name and Address of Entity authorized to release information:**

**Forward information to:**

This information will be used for patient care and shall be in effect until the information has been forwarded as requested.

**Rights of the Patient**

I understand that my treatment will not be conditioned on signing this authorization and that I have the right to refuse to sign this authorization. I understand that information disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by state or federal law.

I understand that I have the right to inspect or copy the protected health information as described in this document.

\_\_\_\_\_ + \_\_\_\_\_

\_\_\_\_\_  
**Signature of Patient or Representative** Date \_\_\_\_\_