Authorization to Release Healthcare Information

(This release request will expire after 30 days of request date)

Patient's Name: ______________________ Date of Birth: ____________

I request and Authorize ______________________________ to release healthcare information to _______________________________________.

(valid for 30 days from date signed)

All records __ Labs__ Pathology__ Office notes__

Other Specified__________________________

Patient Signature: ______________________________ Date: _________

(free)E-mail ☐ ($5) Pick up ☐ ($10) Mail ☐

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