

Release of Information

Company

COMPANY NAME

Contact

123 Maple Street Anytown, PA 17101

info@example.com - www.example.com

(123) 1234567

I, _____, of legal age, with Medical Record Number of _____
and currently residing at _____, do hereby authorize
_____, with the address located at _____
to release my following medical records:

The information to be released shall be for and limited to the purposes of:

This authorization to release the records will remain effective _____
and in this period, the recipient shall use the information in compliance with applicable laws and shall take all kinds of
technical and administrative measures regarding data security.

I know that I can revoke this release of information at any time and without any reason.

Last date of effectivity: _____

This authorization does not permit the recipient to authorize release of my information to a third party without my
written consent.

Signature

By signing below, the individual named above authorizes the release of information described in this form.

Individual named above

Name: _____

Date: _____