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## AUTHORIZATION TO DISCLOSE PERSONAL HEALTH INFORMATION

I hereby authorize the use or disclosure of information from the medical record of:

Patient Name: \_\_\_\_\_, DOB: \_\_\_\_\_, SS#: \_\_\_\_\_

I authorize: \_\_\_\_\_  
(doctor/hospital to get records **FROM**)

to disclose the above named individual's health information to:

\_\_\_\_\_  
(doctor/hospital to send records **TO**)

for the purpose of: \_\_\_\_\_.

Please release the following:

\_\_\_\_\_ **Complete Medical records from:** \_\_\_\_\_ to: \_\_\_\_\_  
\_\_\_\_\_ or Laboratory Results from: \_\_\_\_\_ to: \_\_\_\_\_  
\_\_\_\_\_ or X-Rays, CT Scans, EKGs from: \_\_\_\_\_ to: \_\_\_\_\_  
\_\_\_\_\_ or Physician Statements from: \_\_\_\_\_ to: \_\_\_\_\_

(If I fail to specify an expiration date, event or condition, this authorization will expire in six months)

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient (if Legal Representative)

\_\_\_\_\_  
Witness