AUTHORIZATION TO RELEASE INFORMATION

Name: _____ DOB: _____

PMI#_____ Phone#_____ SSN#_____

_____
Address

_____ _____ _____
City State Zip Code

I, _____, authorize _____.
the release of my personal information, medical records;

_____to

_____
Company/Provider Name (Self/Family Member)

_____.
Address

_____ _____ _____
City State Zip Code

_____ _____
Phone Number Fax Number

I understand that I may revoke this authorization at any time with written notification, but that the revocation will not have any effect on the information released prior to notification of revocation. I also understand that this authorization will automatically expire one year from the date of my signature unless I revoke it earlier. A photocopy/fax of this authorization will be treated in the same manner as an original. Further, I realize that _____ cannot prevent the redisclosure of records released as result of this request and that the records may not be subject to privacy rule protections; therefore _____ is released from any and all liability resulting from redisclosure.

Please fax my request information to _____

at (Fax Number) _____.

_____ _____
Responsible Party/Client Date

_____ _____ _____
Witness Name Relationship to client Date