

**AUTHORIZATION TO RELEASE
HEALTH CARE INFORMATION**

Name _____ Date of Birth _____

Care Card # _____

I request and authorize the release of my health care information to the following person(s)

Name: _____

Relationship (*e.g., son, daughter, parent, friend, family physician, etc.*) _____

This request and authorization applies to:

All health care information

Health care information related to the following treatment, condition, or dates:

Other _____

I hereby authorize the release of my health care information to the person(s) listed above.

Signature: _____

Date Signed: _____