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 or persons:

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:_______________________________________