

Authorization for Release of Information

I authorize _____

Name of sending healthcare professional

Address

City

State

Zip

to exchange records with:

1. _____

Name of receiving person, agency or institution

Phone

Email

2. _____

Name of receiving person, agency or institution

Phone

Email

3. _____

Name of receiving person, agency or institution

Phone

Email

4. _____

Name of receiving person, agency or institution

Phone

Email

Signature of Responsible Party

Date