

### 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