



Authorization for Use and Disclosure of Health Information

Complete all Highlighted Areas

1. Patient name _____ Date of Birth _____

2. Previous name _____ ID# _____
(If applicable) (For Office use only)

On line 4 below give specific and complete name and address of whom you would like your records sent to.

3. By signing this form, I hereby authorize _____

4. To disclose the health information described below to _____

(Name and address of Person or Organization)

In section 5 below please fill in any specifics of what records you need on the lines provided.

5. (Check all that apply):

Any return to work or out of work notes to my employer (fill in): _____

All health information

Health information relating to the following treatment or condition _____

Health information for the date(s) _____

Other specific description _____

6. Reason for This Authorization

At my request

Other (specify) _____ has requested this authorization for marketing purposes and (will/will not) receive compensation from a third party.

