COMPANY NAME
123 Maple Street Anytown, PA 17101

info@example.com - www.example.com
(123) 1234567

Release of Information

I, ______________________________, of legal age, with Medical Record Number of __________________________ and currently residing at ____, do hereby authorize ______________________________, with the address located at ____ to release my following medical records:

The information to be released shall be for and limited to the purposes of:

This authorization to release the records will remain effective ______________________ and in this period, the recipient shall use the information in compliance with applicable laws and shall take all kinds of technical and administrative measures regarding data security.

I know that I can revoke this release of information at any time and without any reason.

Last date of effectivity:

This authorization does not permit the recipient to authorize release of my information to a third party without my written consent.

Name

Date

Signature

____

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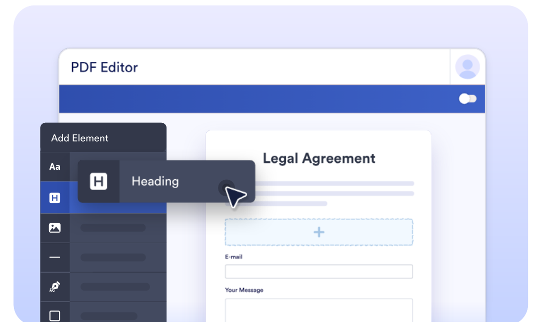

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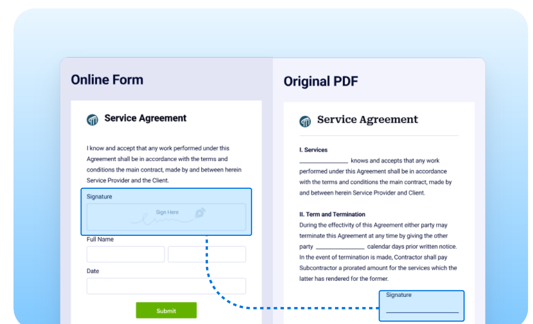

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