

**AUTHORIZATION FOR RELEASE OF  
PROTECTED HEALTH INFORMATION**

Patient Name:

Date of Birth:

I, the undersigned, authorize:

NAME AND ADDRESS

to release or give access to the protected health information of the above-named patient to:

NAME AND ADDRESS (STREET, STATE, ZIP) OF INDIVIDUAL OR ENTITY RECEIVING/ACCESSING RECORDS

Phone:

Fax:

**1. METHOD OF DELIVERY**

**2. FORM**