[**Doctor Name**]
[**Doctor Name**]
[**Doctor Name**]
[**Doctor Name**]
[**Doctor Name**]
[**Doctor Name**]
[**Doctor Name**]

YOUR LOGO HERE

[**Street Address**], [**City, ST ZIP Code**]
Phone: [**Phone Number**] Fax: [**Fax Number**]

TEST AUTHORIZATION FORM

Patient's Name: ______________________ Date of Birth: ______________________

Previous Name: ______________________ Social Security #: ______________________

I request and authorize ____ to release healthcare information of the patient named above to:

Name: ____

Address: ____

City: ______________________ State: __________ Zip Code: __________

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: ______________________

____

☐ All healthcare information

☐ Other: ____

Patient Signature: ______________________ Date Signed: ______________________

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.