AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I, _____, hereby authorize the release of my health information for purposes of continuing medical care.

Patient Name: _____

Date of Birth: _____

Address: _____

Telephone: _____

From- Entity or name with address:

_____

_____

To- Entity or name to receive information with address:

_____

_____

Entire Record _____ or

Specific dates of service: _____

Signature of patient or patient's representative:

_____

Printed name of person signing:

_____