Authorization for Release of Information

I authorize ______________________________

Name of sending healthcare professional

____

Address

____

City State Zip

to exchange records with:

1. ______________________________

   Name of receiving person, agency or institution

   ____

   Phone Email

2. ______________________________

   Name of receiving person, agency or institution

   ____

   Phone Email

3. ______________________________

   Name of receiving person, agency or institution

   ____

   Phone Email

4. ______________________________

   Name of receiving person, agency or institution

   ____

   Phone Email

______________________________ ______________________________

Signature of Responsible Party Date