

**Authorization for Release of
Protected Health Information**



Client: _____

Person authorizing the release of information: _____

Person authorized to receive the information: _____

Information to be released: _____

Information to be released is to be used for: _____

This authorization will expire on the following date, event or condition, if not revoked before that time.

I understand this Authorization may be revoked at any time except to the extent that action has already been taken in reliance on this document. _____

Signature

Date

If this authorization is being signed on behalf of another, it is because: _____
