RELEASE OF MEDICAL INFORMATION AUTHORIZATION FORM

I, _____, hereby authorize (Insert Company Name) to release to _____, (individual or organization authorized to receive medical information) the following medical information from my personal medical records:

_____
_____
_____
_____
(describe information to be released)

I give my permission for this medical information to be used for the following purpose: _____, but I do not give permission for any other use or re-disclosure of this information.

Any other restrictions (i.e. expiration date for this letter; medical information to be created later to be covered by this letter; information in records not intended to be released, etc.)

_____
_____

_____
Print Name of Employee or Legal Representative

_____
Employee or Legal Representative Signature

_____ _____
(Insert Company Name) Representative Signature Date

_____
(Insert Company Name and Address)