

AUTHORIZATION TO RELEASE INFORMATION

This form is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself.

Patient Name \_\_\_\_\_

I \_\_\_\_\_, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

\_\_\_\_\_  
(Please print name)

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
(Please print name)

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
(Please print name)

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date