

REQUEST FOR ACCESS TO PERSONAL INFORMATION
RELEASE OF INFORMATION FORM

The information on this form will be considered as the authorization for personal information to be released, to the patient listed below, OR an appointed representative.

Information YOU are requesting access to?

Your Own Personal Information

Another Person's Personal Information (Consent Needed)

If you are requesting for your own personal information, please complete "Patient Information" section, "Specific Information" and Destination of Information" section and sign.

If you are requesting Another Person's Information, please complete "patient information" section, "Authorized Representative" section, and "Specific Information and Destination of Information" section, Thank you.

PATIENT INFORMATION:

NAME: _____ HEALTH CARD #: _____
ADDRESS: _____ DATE OF BIRTH: _____
SIGNATURE: _____

SPECIFIC INFORMATION/RECORDS REQUESTED:

DESTINATION OF INFORMATION BEING TAKEN (PHYSICIAN, HOSPITAL, THERAPIES, NAME/ADDRESS, ETC)

AUTHORIZED REPRESENTATIVE'S CONTACT INFORMATION:

Relationship to individual YOU are requesting information for: _____
NAME: _____ PHONE#: _____
ADDRESS: _____
SIGNATURE OF REPRESENTATIVE: _____