Authorization For Release of Health Information

Patient	Name	(first) (m,initial) (last)		
	Date of Birth (Alien Registration No.)			
	A d d r e s s			
Legal Representative	Name	(first) (m,initial) (last)		
	Date of Birth		Relationship	
	A d d r e s s			
Type of Medical Record				
Reason for Issuance				

I (Legal Representative) authorize to release my health information including copies of my medical record to the following person or entity _____.

_____/_____/_____(date/ month/year)

_____ (signature)