Risk Form

 Date:

Medical Group or Doctor Name

,

Phone: Fax:

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

|  |  |  |  |
| --- | --- | --- | --- |
| Patient’s Name: |  | Date of Birth: |  |
| Previous Name: |  |  |  |
| I request and authorize |  | to |
| release healthcare information of the patient named above to: |
|  | Name: |  |
|  | Address: |  |
|  | City: |  | State: |  | Zip Code: |  |
| This request and authorization applies to: |
| 🞎 Healthcare information relating to the following treatment, condition, or dates: |  |
|  |  |
| 🞎 All healthcare information |
| 🞎 Other: |  |
| Patient Signature: |  | Date Signed: |  |
| Parent/Guardian Signature:  |
| **\*THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.** |