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.** | | | | | | | | | | | | | | | | | | | |