Medical Authorization Form

Patient Information

Name: ______________________ Date of birth: ____________

Address: ______________________

City: ____________ State: ____________ Zip Code: ____________

Phone Number: ____________ Email: ____________

I ______________________ , hereby authorize ______________________
(Printed Name of Patient) (Printed Name of Authorized Individual)

to obtain medical treatment and care for me during the following period:

Dates of Authorization: ______________________

Description of Medical Treatment Authorized: ______________________

Name of Authorized Health Care Provider: ______________________

Address of Authorized Health Care Provider: ______________________

City: ____________ State: ____________ Zip Code: ____________

Telephone Number of Authorized Health Care Provider:

I authorize the release of all medical information to the authorized individual(s) for the purpose of medical treatment and care. I understand that this information may include information about drug and alcohol abuse, HIV/AIDS, psychiatric or psychological care, and/or communicable diseases.

This authorization shall remain in effect until ______________________ , or until I revoke it in writing.
(Date)

Signature of Patient: ______________________ Date: ____________

Signature of Witness (if applicable): ______________________ Date: ____________

Signature of Authorized Individual: ______________________ Date: ____________