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: _____