

3535 Ross Avenue Suite 101
San Jose, Ca 95124
408-357-3422 (tel) 408-693-3840 (fax)

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to
release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This request authorization applies to:

- Healthcare information relating to the following treatment, condition, or dates: _____

- All healthcare information
- Other: _____

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.