

Authorization for Use, Disclosure, and Release of Health Information

Patient Name: Last _____ First _____ MI _____

Date of Birth: _____

Student ID Number: _____

I hereby authorize: _____ To Release Information to:
(Name and Address of Releasing Facility) (Individual Name, Facility/Organization and Address)

PURPOSE OF DISCLOSURE:

- ' Continuing care
- ' Payment of Claim
- ' School
- ' Worker's Compensation
- ' Legal
- ' For 0 Td [(T)14.7 (o)11 (a)-9.6 (si)-LBody << 0 Td [(T)14.7
