



111 S. Red Bank Rd., Suite B
Evansville, IN 47712
Phone: 812-423-4984
Fax: 812-423-5029

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL HEALTH INFORMATION

I, _____, hereby authorize _____
(Name of Patient or Authorized Agent) (Name of Entity)

(Entity's Street Address, City, State, and Zip Code)

To release all necessary information contained in the patient record of

_____ born _____ ; _____
(Patient's Name) (Birthdate) (SSN)

To _____
(Name of Entity, Street Address, City, State, and Zip Code)

Effective this _____ day of _____, 20_____.
(Day) (Month) (Year)

Signed _____

If you are not the patient, please specify your authorization to sign documents for this patient:

- Legal Guardian
- Parent of Minor
- Power of Attorney
- Executor of Estate