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Clear Form

AUTHORIZATION TO RELEASE NON-MEDICAL RECORDS

I, _____, the undersigned, hereby declare my
Requester
authorization for you to speak with and release copies of my records to the party or entity identified below:

Description of the Records:

Party or Entity:

_____/_____.
Party or Entity Telephone No.

_____
Address

_____
Address (Continued)

As the person signing this consent, I understand that I am giving my permission to the above-named party, entity or other named third party for disclosure of non-public information or records. I also understand that I have the right to revoke this consent, but that my revocation is not effective until delivered in writing to who is in possession of my records.

_____ Signature of Requester	_____ Date	_____ This Consent Expires on (date)
_____ Requester's Social Security Number (optional)	_____ Requester's Date of Birth	_____ Other Identifying Information (Optional)

Additional Information (optional)

The provider shall accept a photocopy, facsimile or copy of the original, signed by the requester, as if it was the original.

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