



**AUTHORIZATION FORM TO SECURE AND
RELEASE MEDICAL INFORMATION**

I _____ hereby grant Methodist Healthcare permission to request information related to my care from the following providers:

(Provider name, phone and fax)

(Provider name, phone and fax)

I understand that this release of information authorization shall remain in effect unless revoked by me at any time by submitting a written request to our office.

Print Name

DOB

Address, City, State and Zip

Phone Number

Signature of Patient or Legal Guardian

Date

Some offices may use your social security number as a way of finding your medical information as another form: it is your option to provide that information here.

Social Security Number