Active Healthcare, Inc.™
helping you breathe easy™

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Medical Release Authorization Form

I understand that:

- I may revoke this Authorization at any time
- The revocation will not apply to information that has been already released
- The revocation will not apply to my insurance company and that the law provides my insurer with the right contest a claim under my policy

Please note that authorizations must be revoked in writing.

I authorize **Active Healthcare** to release the medical records/information for the patient listed below to the following provider.

Send records to:

Provider Name: _____

Address: _____

Fax: _____ Phone: _____

Email: _____

Send records via ☐ FAX Fax Number: _____

☐ Email Email address: _____

_____ _____
Patient Name [Please Print Clearly] DOB

_____
Patient or authorized representative signature

_____ _____
Relationship to patient Date

Please fax completed forms to 919-844-2802 or
Email to: release@activehealthcare.com