

## 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](mailto:release@activehealthcare.com)**