

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 author	orized repres	entative signature	-	
Relationship to patient			Date	
	Please fax	completed forms to 919-8	344-2802 or	

Email to: release@activehealthcare.com