# Valley Internal Medicine & Family Care

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**Authorization for Release of Information**

**Patient Name:** ____________________________________________________________

**Date of Birth:** ____________________________ **SSN #:** ___________________________

**Street Address:** ____________________________________________________________

**City:** ___________________________ **State:** __________ **Zip:** ______________

I hereby authorize (Name of Physician): _______________________________________ to disclose to **Valley Internal Medicine & Family Care** medical records or any other information regarding my treatment, hospitalization, and/or outpatient care.

**Information to be released:** ________________________________________

**Dates of Treatment:** ______________________________________________

**Purpose for disclosing information:** __________________________________

**Date of Signature:** _____________ ____________________________________________

**(Patient Signature)**
**(Patient's Legal Representative/Parent/Guardian)**