Authorization to Release Healthcare Information

Patients Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to release healthcare information of

the patient named above to:

Schuyler County Health Department
213 S. Green St
Lancaster, MO
63548

Fax: 660-457-2238
Phone: 660-457-3721

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

Patient Signature: _____ Date: _____