

**RESIDENT/LEGAL REPRESENTATIVE AUTHORIZATION  
TO RELEASE CONFIDENTIAL INFORMATION**

**RELEASE TO:**

\_\_\_\_\_  
Operator

\_\_\_\_\_  
Address

\_\_\_\_\_  
City/State/ Zip

\_\_\_\_\_  
Telephone

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I here by authorize \_\_\_\_\_  
(Name of physician, or health care provider)

to forward medical records or a summary thereof for \_\_\_\_\_  
(Resident Name)

\_\_\_\_\_  
Resident or Legal Representative

\_\_\_\_\_  
Date

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Comments/Special requests: \_\_\_\_\_

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