AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient's Name _____ Birthdate _____
(PLEASE PRINT) LAST FIRST MI

Address _____

Phone Number _____ Social Security No. _____

I hereby give authorization to:

Name _____

Address _____

to release the following medical information concerning myself to:

Name _____

Address _____

Please send copies of the following specified information. I understand there may be a charge for each page:

☐ Send the following specific information _____

_____

_____

☐ Send only copies of medical records from _____ to _____
month/ year month/ year

☐ Send copies of all medical records.

☐ X-Ray Films (dates) _____
(copies of X-Ray Films will only be sent upon specific request at an additional charge)

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/ or treatment for HIV (AIDS), sexually transmitted diseases, psychiatric disorders/ mental health, or drug and/ or alcohol use. If I have been tested, diagnosed, or treated for (AIDS virus, sexually transmitted diseases, psychiatric disorders/ mental health, or drug and/ or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing, or treatment.

_____ _____
Signature of Patient Date Signed

_____ _____
Witness Date Signed