

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

PATIENT'S NAME: _____ BIRTHDATE: _____
(Please Print) Last First MI

ADDRESS: _____

PHONE NUMBER: _____ ACCT. NO. _____ SOC. SEC. #: _____

I hereby authorize:

NAME: _____

ADDRESS: _____

To release the following medical information concerning myself _____ to

NAME: _____

ADDRESS: _____

Please send the following specific information:

My medical records from _____ to _____
month/year month/year

X-ray Reports _____ Films _____ Date Taken _____

EKG's (date) _____

Laboratory Reports (Date) _____

Other _____

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

Date signed

DATE SENT: _____ BY: _____