Authorization for Release of Medical Information

Patient's Full Name:____

Patient's Address:____

Patient's DOB:________________ Home Phone:______________________

I ________________________ Authorize:____________________________

To Release Information for the above patient to:

____

Phone #:________________________ Fax #:_________________________

_______Release ALL medical records

_______Other (Specify) ____

This release includes but is not limited to any records containing:

1. HIV and Communicable Disease Relation Information.
2. Conditions related to Psychiatric/Psychological Treatment
3. Conditions related to drug and/or alcohol abuse

This release will remain in effect for one year after signed date, unless it is sooner revoked in writing.
Patient, Parent, or Legal Guardian, Please sign below:

Signature:____ Date:_________

Relationship to Patient:______________________________

Reason Patient was unable to sign:_________________________________