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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby grant my permission for release of medical information relating to my care from and to the following parties:

Patient Name: _____

Previous/Current Doctor: _____

Phone: _____ Address: _____

To: (Where do we send) _____

Phone: _____ Address: _____

The Purpose of this release of information is to provide continuity of my care, for processing insurance claims, or to meet another specific desire of mine. I specify that this release includes:

1. Entire Chart – This information might include:
HIV Testing and/or AIDS Treatment, Substance Abuse Treatment and/or Rehabilitation and Psychiatric Testing and/or Treatment.

OR

2. Specific Information to be released: Please specify exactly what you would like submitted (i.e., labs, mammogram results, pathology reports)

_____
_____
_____

I understand that this authorization may be withdrawn at any time in writing. This authorization will remain in effect for 90 days after I sign and date the form. Recipients of my information are forbidden from re-disclosure without my specific authorization. A facsimile may be utilized with the same effectiveness as the original.

Signature_____ Date_____
Print Name_____ Date of Birth_____Phone Number_____