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

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Previous/Current Doctor: \_\_\_\_\_ Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

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)

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I understand that this authorization may be withdrawn at any time in writing.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. I also understand there may be a charge for the processing of this request. Requests for medical records may be subject to a \$27 fee.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Phone Number : \_\_\_\_\_