AUTHORIZATION TO RELEASE MEDICAL INFORMATION

PATIENT INFORMATION

Name:_____

Address:_____

City/State ZIP:_____

Phone (____)_____ DOB___/___/____

I HEREBY AUTHORIZE AND REQUEST (Where records are located)

Name:_____

Address:_____

City/State ZIP:_____

Phone (_____)_____Fax (_____) _____

To Disclose/Release the following information:

_____Two years back from current date

_____Other-please be specific_____

*Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.

PLEASE SEND THE RECORDS LISTED ABOVE TO:

Name: _____

ADDRESS: _____

CITY_____ STATE: _____ ZIP: _____

PHONE: _____ FAX: _____

I understand this authorization becomes effective immediately and will remain so until revoked by me in writing.

I understand that the requester may not lawfully further use or disclose the heath information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

DATE: _____ SIGNED: _____

WITNESS: _____ RELATIONSHIP _____