AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: ______________________________________ DOB:____________
Last First

Address: ____
City State Zip

I hereby authorize ______________________________________M.D.
Address: ____
____

To release the following information: ______All records ____ 5 Year History
__________________Notes Only

To: ____
____
____

- **We will not release information from previous healthcare providers. Please contact them directly.**

This authorization is valid for 90 days and may be revoked at any time in writing prior to the Expiration date. Additional authorization for redisclosure beyond recipient is required.

Patient Signature: ______________________________ Date:______________

Guardian signature: ________________________________

*** RELEASE FOR SENSITIVE INFORMATION:**

I UNDERSTAND THAT IF MY MEDICAL RECORDS CONTAINS INFORMATION IN REFERENCE TO DRUG AND/OR ALCOHOL ABUSE, PSYCHIATRIC, VENEREAL DISEASE, SOCIAL SERVICE, ABUSE, ABORTION, AND/OR SENSITIVE INFORMATION, I AGREE TO RELEASE.

*Signature:*_________________________________ *Date:*___________________

*** RELEASE OF HIV INFORMATION:**

In addition to the above signatures. If you want your HIV (AIDS) testing/treatment records released you must sign and date on the line below.

I AGREE TO THE RELEASE OF THIS INFORMATION

Signature: ______________________________ Date:__________________

Please enclose a payment of $15/record (maximum of $30/family) to cover the cost of copying and transferring of records.