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AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

Patient's Name:_____ Date of Birth:_____

I authorize: _____
(Doctor or Hospital)

to release all of my medical records including any information related to medical, psychiatric, drug and/or alcohol, and HIV related treatment to:

☐_____
(Doctor or Hospital Name, Address, Phone and Fax Number (if available)

If I specify a period of records to be released, I will do so below. Otherwise, I would like all my medical records to be released.

From: _____ to _____

or ☐ myself via ☐ mail ☐ E-mail _____
(only the most recent office note will be released to the patient unless otherwise specified in the release)

This authorization may be revoked by me at any time, except to the extent that action has been taken thereon.

Name:_____ Date: _____
Address:_____

Signature:_____ Witness:_____
(If relative, or under 18 years of age, state relationship to patient.)

The following are a part of the release form to the extent applicable:
HIV Related Information: "This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by state law. A general authorization for the release of medical or other information is not sufficient for this purpose."