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AUTHORIZATION TO RELEASE RECORDS

DATE ______________________

NAME ____

ADDRESS ____

DATE OF BIRTH ____

SS# ____

REASON FOR RELEASE OF RECORDS ____

____

I, ______________________ AUTHORIZE DR. ______________________________

____

____
(MAILING ADDRESS AND/OR PHONE/FAX #)

TO RELEASE PHOTOCOPIES OF THE FOLLOWING MEDICAL RECORDS TO:

____

____

____
(MAILING ADDRESS AND/OR PHONE/FAX #)

I DO/DO NOT (CIRCLE ONE) CONSENT TO THE RESLEASE OF HIV-(AIDS), STD RELATED, ALCOHOL AND/OR DRUG ABUSE TREATMENT OR PSYCHIATRIC INFORMATION AS PART OF THE AUTHORIZATION.

MEDICAL RECORDS (CIRCLE ONE)
ALL MEDICAL RECORDS
OR
THE FOLLOWING DESCRIBED RECORDS ONLY (SPECIFY TYPES AND DATES)

____

____
PATIENT SIGNATURE

____
PARENT/LEGALLY AUTHORIZED REPRESENTATIVE

____
RELATIONSHIP TO PATIENT