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AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name:
DOB:

I request and authorize the following entity:

Name:	
Address:	
Phone:	**Fax:**

To release health care information of the patient named above to:

Name:		
Address:		
City:	**State:**	**Zip:**
Phone:	**Fax:**	

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition or dates:

____

☐ All Healthcare information

☐ Other: ____

☐ YES ☐ NO I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ YES ☐ NO I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Purpose of disclosure:

☐ Specialist referral ☐ Continuing Care ☐ Updating Personal Records
☐ Insurance Request ☐ Change of Doctors ☐ Other:_______________

I realize that by signing this form that I am authorizing the release of my medical information. I understand that the information used or disclosed may be subject to redisclosure by the person or facility receiving it. I understand I may cancel this request at any time with written notification. I understand there may be a charge for record copying services and I am responsible for paying these fees.

Signature ______________________________ **Date** ______________________________