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Medical Records Release Form

Patient Name: _____ Date of Birth: _____

Address: _____

_____

Phone: _____

I hereby authorize: _____

To send/release photocopies of medical records concerning the above patient to:

Name/Practice: _____

Address: _____

_____

For the purpose of: _____

Medical Records (Check One):

[ ] All medical records of past two (2) years of treatment

[ ] The following described records only (specify type/date(s)

_____

This authorization is valid for 60 days after the signed date below. I may revoke this authorization at any time providing written notification is provided. I agree that a photocopy of this authorization is as valid as the original. I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

Exclude the following information from the records released (please initial):

[ ] Drug/Alcohol abuse/treatment

[ ] Sexually Transmitted Disease

[ ]HIV/AIDS diagnosis treatment/testing

[ ] Mental Illness or psychiatric Diagnosis/Treatment

Signature: _____ Date: _____

Patient, Guardian, or Authorized Representative