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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I, _____
Print Patient's name

SS#: _____ DOB: _____

Authorize: Name: _____

Address _____

City, State, & Zip Code: _____

Phone: _____

Fax:_____

To release a **COPY/SUMMARY** of my medical records to:

Name: _____

Address _____

City, State, & Zip Code: _____

Phone: _____

Fax:_____

I understand that the specific reports disclosed shall include (last labs, biopsy):

_____

_____*(Note: If your records are to include AIDS/HIV status, mental health records or drug/alcohol history, you must list them in the space above)*

I understand that this consent is revocable upon written request to the practice, except to the extent that action by the practice has been taken in reliance on this authorization and that this authorization shall remain in force for a reasonable time in order to effect the purpose for which it is given.

Patient Signature: _____ Date:_____

Witness: _____ Date:_____

THIS RELEASE FORM IS ONLY GOOD FOR 1 YEAR FROM DATE SIGNED