AUTHORIZATION TO RELEASE INFORMATION

Please Print Clearly

Patient Name _____

Last First Middle

Address _____

Street City State Zip code

Phone _____ Date of Birth _____ Social Security # _____

I authorize _____ to release medical information from my medical record to:

Name of Doctor, Hospital etc. _____

Address: _____

City/State/Zip Code: _____

For the purpose of review/examination and further authorize you to provide such copies (thereof as me be requested). The following is subject to such limitations as indicated below:

- ☐ Entire Record
- ☐ Specific Information _____
- ☐ Old Records from Previous Physicians
- ☐ Other Physicians & Facilities _____

I give special permission to release information regarding: (initial on line(s) below that you grant permission to release the information to the above)

___Substance Abuse ____Psychiatric/Mental Health Information ____HIV information

Reason for Request: _____

Signed: _____ Date: _____

Witness: _____ Date: _____

FOR OFFICE USE ONLY

Date Received: _____ Completed By: _____

Completed By: _____ Fee Paid: _____

Disclosure Consisted of: _____

_____