AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

I hereby authorize (Name of facility/Doctor): ____

Address: ____ to release and/or disclose the medical information as indicated below to:

____

Release and/or disclose records and information regarding:

__________________________________ __________ ______________________________
Name of Patient Date of Birth Phone Number

Covering the period of healthcare: From (date) _______________ To (date)_________________

Information to be disclosed:

☐ Complete health record (s) Or if partial record:
☐ Progress Notes ☐ Consultation Reports
☐ Laboratory Tests ☐ X-Ray Reports
☐ Other (Please specify)
____

I understand that this will include information relating to (check if applicable):

☐ Acquired Immunodeficiency Syndrome (AIDS) or infection with HIV
☐ Psychiatric Care
☐ Treatment for alcohol and/or drug abuse

I understand this authorization may be revoked in writing at any time, except with respect to action that has already been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following date, event or condition: ____________________

The facility, its employees, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein,

Signed: ____ _________________
(Patient/Parent or Legal Representative) Date

Relationship to Patient ____