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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Please send a copy of this release with the requested records.

PATIENT INFORMATION (Please print)			
Patient Name		Date of Birth	Social Security Number
Address	City	Zip	Phone

RELEASE FROM: (NAME OF PHYSICIAN OR FACILITY RELEASING INFORMATION)			
I authorize release of my medical record from			
Physician/Facility			
Address	City	Zip	Phone

RELEASE TO: (NAME OF PHYSICIAN OR FACILITY RECEIVING INFORMATION)			
Please send my medical record to:			
Physician/Facility			
Address	City	Zip	Phone

RELEASE INFORMATION

Reason: ( ) Change of insurance ( ) Transfer of Care ( ) Personal file
( ) Moving out of area ( ) Specialist consultation ( ) Legal

Please release the following (check all that apply)

RECENT H&P		LAST THREE VISITS	
LAB REPORTS		X-REAY REPORTS	
HOSPITAL REPORTS		OTHER:	

Please allow 15 days for processing.
Incomplete information will delay processing.
Use of his information for any other than the stated purpose is prohibited.
This information is for the use of the designated recipient only and cannot be provided to any other agency.

CONSENT

I authorize release of all information indicated, and I am aware that the records released may contain information relating to psychiatric or psychological testing, physical abuse, or drug and alcohol abuse.

	YES	NO	Initials
I authorize the release of HIV/HTLV/AIDS test results.			
I understand that I may be charged for copies provided.(See reverse side.)			

Signature of patient, guardian, conservator, or patient representative (Please circle)	DATE
Witnessed by	DATE

Note: This consent is valid for 90 days. It may be revoked by the signer at any time.