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AND
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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

_____
(Patient Name – include previous if necessary for request)

_____
(Date of Birth)

_____ _____ _____
(Address) (Home Phone)

_____ _____ _____
(City, State, Zip) (Social Security Number)

Release from: _____

I authorize the following information be sent to: _____

Phone number: _____ Fax number: _____

____ Copies of all medical records for the period: _____ to _____

____ Copies of the information described below for period: _____ to _____

____ History & Physical Examination ____ Lab, X-Ray, Reports ____ Reports from other physicians

____ Other (Please specify) _____

_____

I understand that this information may include any history or acquired immunodeficiency syndrome (AIDS), sexually transmitted diseases, human immunodeficiency virus (HIV) infection, behavioral health service/psychiatric care and/or drug abuse, or similar conditions.

____ I do ____ I do NOT (one must be checked)

I authorize release of information related to AIDS (acquired immunodeficiency syndrome), HIV (human immunodeficiency virus) infection, psychiatric care and/or psychological assessment and treatment for alcohol or drug abuse.

Signature of Patient or Parent/Legal Guardian Authorized Representative if patient is a minor (under 18 years).

_____ _____
Signature (Full Name) Date

Is this a permanent transfer? ____ Yes ____ No

Attention: _____