



## **Authorization for Release of Medical Information**

Patient's Full Name: \_\_\_\_\_

Patient's Address: \_\_\_\_\_

Patient's DOB: \_\_\_\_\_ Home Phone: \_\_\_\_\_

I \_\_\_\_\_ Authorize: \_\_\_\_\_

To Release Information for the above patient to:

\_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

\_\_\_\_\_ Release ALL medical records

\_\_\_\_\_ Other (Specify) \_\_\_\_\_

This release includes but is not limited to any records containing:

1. HIV and Communicable Disease Relation Information.
2. Conditions related to Psychiatric/Psychological Treatment
3. Conditions related to drug and/or alcohol abuse

**This release will remain in effect for one year after signed date, unless it is sooner revoked in writing.**

**Patient, Parent, or Legal Guardian, Please sign below:**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Reason Patient was unable to sign: \_\_\_\_\_