AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____hereby authorize

Dr. _____

Address: _____

Phone: _____Fax: _____

To disclose any health information, including copies of medical records, labs and/or x-ray records to:

Dr. _____

Address: _____

Phone: _____ Fax: _____

Please DO NOT FAX RECORDS if more than 20 Pages.

Should my medical records contain the following information, by my **initials**, I:

_____ Consent _____ Do Not Consent

to the release of information pertaining to alcohol and/or drug abuse and/or psychiatric record and/or any condition related to a sexually transmitted disease and/or HIV (Human Immunodeficiency Virus), AIDS (Acquired Immune Deficiency Syndrome) or ARC (AIDS Related Complex).

- This authorization shall cover the period of time from my first visit to my last visit.
- I understand that I can revoke this authorization at any time
- This authorization shall end two years after the date of my last visit.

Patient's Name:_____

Date of Birth: _____ Social Security #: _____

Name and relationship of person signing, if not the patient: _____

Signed:_____ Date:_____

(Name of patient, parent/legal guardian, or representative)

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