

CONSENT TO RELEASE MEDICAL INFORMATION

Patient Name _____ Date of Birth _____
Address _____ Phone No. _____
City, State, Zip _____ Maiden Name _____

I hereby authorize: Name of Provider _____
Address _____
Phone No. _____ Fax No. _____

To disclose the following medical information to:

Name of Provider _____
Address _____
Phone No. _____ Fax No. _____

Information to be disclosed:

_____ Any and all of my medical record (as of the date of this release)
_____ Any and all of my medical records for the following dates: From(date) _____ To(date) _____
_____ Any and all of my record *except* the following: _____
_____ Other (Please specify) _____

Including information related to the treatment for substance abuse or dependency, psychiatric or mental health treatment; information related to testing or treatment of sexually transmitted diseases and HIV/AIDS.

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By signing below, I acknowledge that I have read and understood this entire document, and I have voluntarily given my consent to release (or obtain) my medical records. I also understand I may revoke this authorization and consent at any time except to the extent that the release of information has previously taken place before the date of revocation.

Patient Date

Or Legal Representative (Relationship to patient) Date

Witness Date