AUTHORIZATION TO RELEASE INFORMATION

Name_____
(Last) (First) (Initial)

Address_____
(Street) (City) (State) (Zip)

Phone(____)_____Date of Birth_____SS#_____

I authorize_____to release medical information from my medical record to be sent to:

Name_____

Address_____

City/State/ZipCode_____

I authorize you to release

___My entire medical record without limitations
___My medical record except for information in regards to HIV/AIDS
___My medical record except for information in regards to Mental Health
___My medical record except information in regards to Substance Abuse
___My medical record from other physicians I have seen, that the doctor has in my file
___My pathology slide or block #_____

This authorization will automatically expire one year from the date signed. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance thereon.

Signed_____ Date_____
(If not patient, state relationship)

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FOR OFFICE USE ONLY

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Received_____ Sent_____

Release consisted of_____