AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient Name ______________________________

Date Of Birth ______________ **S.S.#** ______________

I request and authorize:

Name ______________________________

Address ______________________________

City ______________________________

Phone ______________________________

Fax ______________________________

TO RELEASE INFORMATION ON THE ABOVE NAMED PATIENT TO:

Name ______________________________

Address ______________________________

City ______________________________

Phone ______________________________

Fax ______________________________

This request and authorization applies to:

________ Health care information relating to the following treatment, condition, or dates of treatment______________________.

________ All health care information.

________ Other ______________________________

I understand that my expressed consent is required when authorizing the release of any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use.

Signature of Patient or authorized representative: ______________________

Relationship if signed by other than Patient: ______________________

Date: ______________________