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CONSENT FOR RELEASE OF MEDICAL RECORDS

Patient's Name: _____
Address: _____
_____
Date of Birth: _____

RECEIVE Records
From: _____
_____
_____
Phone: _____ Fax: _____

I hereby consent and authorize you to release copies of my medical record, including current and previous medical records from other practices and hospitals, and/or clinics, which are part of my medical records. PLEASE NOTE: this authorization includes consent for the release of alcohol, drug, psychiatric and psychological information: and any information relation to pregnancy, sexually transmitted diseases, HIV testing, AIDS, and any AIDS-related syndromes. It also includes any information concerning cancer, cancer testing, and cancer results. I agree that a copy of this release shall be as valid as this original release. Please send copies of all requested information as soon as possible to the address listed below:

SEND Records
To: _____
_____
_____
Phone: _____ Fax: _____

___ SEND ALL OF MY MEDICAL RECORDS
___ SEND RECORDS FROM (DATE) _____ TO (DATE) _____
___ SEND MY RECORDS PERTAINING TO _____

Patient's Signature: _____

Date: _____

Witness: _____