AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient Name: _____
Birthdate: ___/___/___ Social Security Number: _____

I, the undersigned, herby authorize: _____
Name of Healthcare Provider/Facility to release information

_____
Street Address

_____
City State Zip Code

_____
Phone Number Fax Number

To release information as designated to: _____
Name of person/Organization to receive information

_____
Street Address

_____
City State Zip Code

_____
Phone Number Fax Number

With the following information:

◯Progress Notes ◯Radiology Reports ◯Special Procedure Reports
◯Consultation Report (s) ◯Emergency Report (s) ◯Medications/Treatments
◯Physician Orders ◯EKG/Stress Test Reports ◯Other: _____
◯Immunization Record ◯Discharge Summary (s) ◯History & Physical
◯Operative Report (s) ◯Entire Record

Purpose of disclosure: _____

I understand and acknowledge that this authorization extends to all or part of the medical Records as indicated above and may include infomati0on regarding psychiatric disorders, Human Immune Virus (HIV) testing results, Acquired Immune Deficiency Syndrome (AIDS), AID's related conditions, and alcohol and/or drug dependency/abuse/treatment.

I understand I may revoke this authorization at any time except to the extent that action has been taken thereon. In any event, this consent expires automatically in 60 days from the date in which I have signed. Re-disclosure of this information by the receiving party is strictly prohibited.

Regina Hill MD, Inc. will make every effort to ensure timely completion of request to release medical information.

_____	_____
Signature of Patient/Parent/Legal Guardian	Date