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Authorization for the Release of Medical Information

I _____ hereby authorize _____

located at _____
(Address) (City) (State) (ZIP)

to release the following information to _____

located at _____
(Address) (City) (State) (ZIP)

Please release my entire medical chart unless specific information is noted below:

_____

_____

By State Law, you must be advised that:
The information you authorize for release my include information that could be considered information about communicable or non communicable venereal diseases which may include, but are not limited to diseases such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus, also know as Acquired Immune Deficiency Syndrome (AIDS).

I realize by the receipt and/or release of these records that I am accepting responsibility for the protection of my own right of medical record confidentiality.

_____ _____ _____
Patient's Printed Name Date of Birth Social Security Number

_____ _____
Patient's Signature Date of Request