



AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize J. Judson Shelnutt, MD to release healthcare information of the patient named above to:

Name: _____

Address: _____

Fax: _____

This request and authorization applies to: (Please check one)

Healthcare information relating to the following treatment, condition, or dates:

All healthcare information

Yes No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above.

Yes No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.