

This authorization allows the healthcare provider(s) named below to release confidential medical information and records. Note: *Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.*

AUTHORIZATION

I hereby authorize: _____
Physician/Healthcare Facility

To release information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records by means of mail, fax or other electronic methods.

To: _____
Name

Address

City State Zip Code

The medical information/records will be used for the following purpose: _____

This authorization is:

- Unlimited (all records, excluding Substance Abuse, Mental Health, HIV Diagnosis/Treatment)
- Limited to the following medical information: _____

I also consent to the specific release of the following records:

Drug/Alcohol/Substance Abuse	_____ (initial)	Tests for Antibodies to HIV	_____ (initial)
Psychiatric/Mental Health	_____ (initial)	HIV Diagnosis/Treatment	_____ (initial)

DURATION This authorization shall be effective immediately and remain in effect until _____
Date

RESTRICTIONS

Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

A photocopy of facsimile of this authorization shall be considered as effective and valid as the original.

I have been advised of my right to receive a copy of this authorization.

_____ Signature of Patient	_____ Relationship if other than patient
_____ Patient's Name (PRINT)	_____ Date
_____ Patient's Social Security Number	_____ Patient's Date of Birth
_____ Witness Name	_____ Witness Signature



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