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## Authorization to Release Medical Records/Information

From: _____

Patient's Name: _____

Social Security #: _____ DOB: _____

To: _____

I authorize the health care provider to release the information specified below to the organization, agency or individual named on this request. I specifically authorize the release of the information regarding the following condition(s): Initial

_____ Drug abuse, if any

_____ Substance abuse, if any

_____ Psychological of psychiatric conditions, if any

_____ AIDS/HIV, if any

Release these records: Initials

1. Records generated by this facility (not including records received from other sources) _____
2. Only some portion of records maintained at facility (specify below) ..... _____
3. All medical records at this facility ..... _____

_____

_____

Expiration or revocation of authorization – I understand that I may revoke this authorization at any time. Use of copies – A copy of this authorization may be utilized with the same effectiveness as an original.

Patient's name (print):

_____

Patient's signature:

_____

Date: _____

Person authorized to sign for patient: (print)

_____

Signature:

_____

Relationship to patient:

_____

Date: _____

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