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AUTHORIZATION FOR RELEASE/REQUEST OF MEDICAL INFORMATION

Patient's Full Name: _____

Phone: _____

Street Address: _____

SSN#: _____

City/State/Zip: _____

Date of Birth: _____

Request Information From:

Release Information To:

Name of Company/Agency/Facility/Person

Name of Company/Agency/Facility/Person

Street Address

Street Address

City/State/Zip

City/State/Zip

Phone / Fax

Phone / Fax

Authorize Release of Information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment and treatment for alcohol and/or drug abuse.

Yes ___ No ___

Information Needed For: Attorney ___ Insurance Company ___ Self ___ Other _____

Is this also a transfer of your medical care? Yes ___ No _____

Records to be mailed _____ faxed _____ picked up _____

Complete Record _____

Partial Record _____

(Indicate info needed and date range...for example, MRI reports 2006, Op Note from 06-13-07...etc.)

Signature: _____ Witness: _____ Date: _____

Please allow at least 7-10 business days for your request to be completed. Charges may apply.
Records are transferred to other physicians as a courtesy; charges will apply when sent directly to patient.
This authorization expires 90 days from date signed.