# AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENTS NAME:

PATIENTS DOB: / /

PATIENTS LAST 4 DIGITS OF SSN:

## INFORMATION TO BE RELEASED *TO:*

Request Information must have complete address and fax number

Organization/Person Name

Street Address City: State:

Phone: Email: Fax:

Release all Medical Records Including:

☐ HIV Status ☐ Mental Status ☐ Substance Abuse Status

## INFORMATION TO BE RELEASED *BY:*

Request Information must have complete address and fax number

Organization/Person Name

Street Address City: State:

Phone: Fax:

Release all Medical Records Including:

☐ HIV Status ☐ Mental Status ☐ Substance Abuse Status

I HEREBY AUTHORIZE THE RELEASE OF THE MOST CURRENT CHART NOTES, SUMMARY, LABS, MAMMOGRAM, COLONOSCOPY & DIAGNOSTICS RESULTS OF THE ABOVE NAMES PERSON. AUTHORIZATION EXPIRES IN 365 DAYS UNLESS REVOKED IN WRITING.

NAME OF PATIENT (PLEASE PRINT)

SIGNATURE OF PATIENT OR LEGAL GUADIAN

DATE