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PATIENT MEDICAL RELEASE FORM

Patient Name: _____ DOB: _____
Address: _____ Telephone: _____
City: _____ State: _____ Postal Code: _____
Releasing From: _____ Releasing to: _____

I authorize the release of: (please initial)

___ All Records ___ Chart Notes ___ Lab records
___ X-Ray, MRI, CT Reports ___ EKG ___ Other (Please specify)

I understand that this may include information related to:
*Sexually transmitted diseases, Acquired Human Immunodeficiency Syndrome (AIDS)
*Human Immunodeficiency Virus (HIV)
*Behavior or Mental Health Services
*Treatment for Alcohol and/or drug abuse

This information is to be disclosed for the purpose of: _____

Specify the date, extent, or condition upon which this authorization expires: _____
I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and that the revocation will not apply to information already released on this authorization. Unless otherwise noted, or revoked, this authorization will expire in 1 year from today's date. _____ (Initial)

Signature of patient or legal representative Date

Printed name of patient or legal representative Relationship to patient

- Prior to release, the following must be provided:
- Photo ID (Valid Drivers License or passport)
 - Copy of Photo ID, if requesting by mail, or facsimile, or email
 - Copy of Power of Attorney (if required)
 - Physical Street address for records that are to be mailed (NO PO BOX)

Received: _____ Completed by: _____ Faxed by: _____ ID Checked: _____

