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CONSENT FOR RELEASE OF MEDICAL RECORDS

FROM: Patient's Name _____
Patient's Address _____
Patient's Birth Date _____
Patient's Social Security Number _____

TO: _____
_____
_____

I do hereby consent and authorize you to release copies of my medical records, including current and previous medical records from other practices and practitioners, hospitals, and/or clinics which are a part of my medical records. PLEASE NOTE: This authorization includes consent for the release of alcohol, drug, psychiatric and psychological information: and any information relating to pregnancy, sexually transmitted diseases, HIV testing, AIDS, and any AIDS-related syndromes. It also includes any information concerning cancer, cancer testing, and cancer results. I agree that a copy of this release or a fax of this release shall be valid as this original release. Please send copies of all requested information as soon as possible to the address listed below:

____SEND ALL OF MY RECORDS
____SEND RECORDS FROM (DATE) _____ TO (DATE) _____
____SEND MY RECORDS PERTAINING TO _____

SEND RECORDS TO:

_____
_____
_____

_____
Patient's Signature

_____
Date

_____
Witness