AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This authorization allows the healthcare provider(s) named below to release confidential medical information and records. Note: *Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions or alcohol/substance abuse have special rules that require specific authorization*.

I hereby authorize: ____

Physician/Healthcare Facility Phone Number

To release information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including correspondence and/or medical records.

To: ____

Name

____

Address

____ ____________________________________

Phone Number Fax Number

This authorization is:

_____ Unlimited (all records, excluding Substance Abuse, Mental Health, HIV Diagnosis/Treatment)

_____ Limited to the following medical information: ____

I also consent to the specific release of the following records:

Drug/Alcohol/Substance Abuse __________ (initial) Tests for Antibodies to HIV __________ (initial)

Psychiatric/Mental Health __________(initial) HIV Diagnosis/Treatment __________(initial)

This authorization shall be effective immediately and remain in effect until ____

Permissions for further use of disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

A photocopy or facsimile of this authorization shall be considered as effective and valid as the original.

I have been advised of my right to receive a copy of this authorization.

____ ____

Signature of patient *or legal/personal representative* Relationship *If other than patient*

____ ____

Patient's Name (PRINT) Date

____ ____

Patient's Social Security Number Patient's Date of Birth

____ ____

Witness Name Witness signature