# Authorization For Release Of Medical Information

For _____ _____
(patient's name) (date of birth)

I, _____
(patient or legal guardian)

authorize _____
(prior physician or medical facility)

to release the following
medical information to: _____

_____

_____

_____ Any and all of my medical record (as of the date of this release)
_____ Any and all of my medical record **except** the following:

_____

This release also specifically allows the release of the following information
(this information **will not** be released unless the appropriate box is initialed)

_____ Any record of treatment for Drug and/or Alcohol dependency or abuse
_____ Any record of Mental Health treatment
_____ Any record of testing, care, treatment, reporting or research pertaining to infection with HIV or related diseases

This information is being released for the following purpose(s) only: _____

_____ and may not be used for any other purpose or released to any other person(s) without my written consent.

This release is effective for six months from the date of execution, however, it may be revoked by me at any time by providing notice in writing to the above named party.

S/_____ Date _____
(patient/legal guardian of patient)

S/_____
(witness)