

## Authorization to Release Medical Records

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Patient's Address: \_\_\_\_\_

I, or my authorized representative, request that health information regarding my care and treatment be released as indicated below. I understand that:

1. My records may include information relating to alcohol and drug treatment, mental health treatment, and confidential HIV/AIDS and other sexually transmitted infection information unless excluded in section 7.
2. I have the right to revoke this authorization at any time in writing, unless action has already been taken on this consent.

3. Release To (name and address of provider): _____ _____ Fax:( ) Phone:( )																	
4. Release From (name and address of provider): _____ _____ Fax:( ) Phone:( )																	
5. Purpose for the Release of Records:																	
6. The information below may be disclosed from: _____ until _____ <small>INSERT START DATE</small> <small>INSERT STOP DATE</small>																	
<input checked="" type="checkbox"/> All health information, except as follows (if checked and initialed):																	
<table border="1"><thead><tr><th>Indicate the specific information <b>NOT</b> to be released and initial below.</th><th>Additional explanation/comments on information to be <b>WITHHELD</b>, if any.</th><th>Initials</th></tr></thead><tbody><tr><td><input type="checkbox"/> Records from alcohol/drug treatment programs</td><td></td><td></td></tr><tr><td><input type="checkbox"/> Clinical records from mental health programs</td><td></td><td></td></tr><tr><td><input type="checkbox"/> HIV/AIDS - related information</td><td></td><td></td></tr><tr><td><input type="checkbox"/> STI - related information</td><td></td><td></td></tr></tbody></table>			Indicate the specific information <b>NOT</b> to be released and initial below.	Additional explanation/comments on information to be <b>WITHHELD</b> , if any.	Initials	<input type="checkbox"/> Records from alcohol/drug treatment programs			<input type="checkbox"/> Clinical records from mental health programs			<input type="checkbox"/> HIV/AIDS - related information			<input type="checkbox"/> STI - related information		
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<input type="checkbox"/> STI - related information																	
7. If not the patient, name of person signing form:	8. Relationship to the patient:																

\_\_\_\_\_  
SIGNATURE OF PATIENT OR REPRESENTATIVE DATE

Witness Statement/Signature: I have witnessed the execution of this authorization.

\_\_\_\_\_  
WITNESSES' NAME AND TITLE SIGNATURE DATE