

**Practice Name**  
**Phone • Fax**  
**Authorization for Release of Medical Record Information**

Name: <u>pm_firstname pm_mi pm_lastname</u> Address: <u>pm_street</u> City: <u>pm_city</u> State: <u>pm_state</u> Zip: <u>pm_zipcode</u> Telephone No.: <u>pm_homephone</u>	Date of Birth: <u>pm_birthdate</u> Medical Record No.: _____
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I hereby authorize:

**Name: Practice Name**    **Address:**  
**City:**                    **State:**                    **Zip:**

to disclose information from my / my minor child's medical records to (name and address):

Name: \_\_\_\_\_ Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

I hereby authorize re-disclosure of this information to:

Name: \_\_\_\_\_ Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

This information is needed for the following reason:

\_\_\_\_\_

The specific information I wish to have released is (included dates of treatment):

\_\_\_\_\_

I understand that I may revoke this consent at any time, except where information has already been released. This authorization is valid for a sixty (60) day period from the date it is signed.

\_\_\_\_\_  
Signature: (Parent or Legal Guardian if Minor Child)

\_\_\_\_\_  
Date:

Expires: \_\_\_\_\_

Witness: \_\_\_\_\_

This medical record may contain information about drug abuse, alcoholism, alcohol abuse, venereal disease, abortion, or mental health treatment. Separate consent must be given before this information can be released.

- I DO consent to have this information disclosed.
- I DO NOT consent to have this information disclosed.

\_\_\_\_\_  
Signature: (Parent or Legal Guardian if Minor Child)

\_\_\_\_\_  
Date:

This medical record may contain information concerning HIV testing and / or AIDS diagnosis treatment. Separate consent must be given before this information can be released.

- I DO consent to have this information disclosed.
- I DO NOT consent to have this information disclosed.

\_\_\_\_\_  
Signature: (Parent or Legal Guardian if Minor Child)

\_\_\_\_\_  
Date: