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## AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Please complete form thoroughly.
Your medical records cannot be released until this form is completed, signed by the patient or legal guardian

**STEP 1: Patient Information:** **PLEASE PRINT**

**Patient Name:** _____ (Last) _____ (First) **Date of Birth:**_____ **SS Number:** _____

**Address:** _____ (Street) _____ (City) _____ (State) _____ (Zip)

**Telephone number:** _____ (Home) _____ (Work)

**STEP 2 Physician Information:**

**I hereby authorize:** _____ **M.D.** **Phone:** _____

**Address:** _____ (Street) _____ (City) _____ (State) _____ (Zip)

**STEP 3 To review my medical information with the following people:**

**Name:** _____ **Relationship:** _____ **Telephone number:** _____

**Name:** _____ **Relationship:** _____ **Telephone number:** _____

**STEP 4 SIGNATURE** **Date:**_____

**This authorization is valid for 90 days and may be revoked at any time in writing prior to the expiration date. Additional authorization for re-disclosure beyond 90 days is required.**

_____ (Patient's Signature) **or** _____ (Parent/Guardian's Signature) _____ (Witness Signature)

**STEP 5 Release for SENSITIVE INFORMATION:** **Date:** _____

**I understand that if my medical record contains information in reference to drug and/or alcohol abuse, psychiatric, venereal disease, social service, hepatitis b testing/treatment, and/or sensitive information, I agree to its release:**

_____ (Patient's Signature) **or** _____ (Parent/Guardian's Signature) _____ (Witness Signature)

**STEP 6 Release for HIV INFORMATION:** **Date:**_____

**In addition to the above signatures, if you want your HIV (AIDs) testing/treatment records released you must sign on the line below:**

_____ (Patient's Signature) **or** _____ (Parent/Guardian's Signature) _____ (Witness Signature)

**IT MAY TAKE 7-10 DAYS TO PROCESS THIS REQUEST**

**Office use only:** **Date chart copied:** _____ **Copied by whom:** _____ **(initials)** **Date released:** _____