CONSENT TO RELEASE MEDICAL, PSYCHIATRIC,
AIDS/ARC/HIV TESTING, ALCOHOL OR DRUG ABUSE PATIENT RECORDS

1. I hereby authorize my physician at_____
   ☐ To RELEASE copies of my medical records to:_____

   ☐ To RECEIVE copies of my medical records from: _____
   _____
   _____

2. I understand that my records may contain information pertaining to my diagnosis or treatment of my medical, psychiatric, AIDS/ARC/HIV testing, alcohol or drug abuse condition. I also understand that any topic discussed during my medical treatment was documented, and therefore, will be released:_____ _____
   Signature Date

3. Information to be released/requested: (please circle)

OFFICE NOTES	LAB	X-RAYS	EKG	HOLTER	ECHO
D/C SUMMARY	OP NOTES	H & P	BILLING INFO	DX	ALL

   DATES OF SERVICE(S): _____

4. I understand that this release can be revoked at any time, except to the extent that disclosure made in good faith has already occurred in reliance on this consent. To revoke this consent, written notice must be given.
5. This consent expires in 90 days.

6. _____(Current Physician) is released from any legal responsibility of liability; for the release of the above information to the extent indicated and authorized herein.

Signed:_____ Date:_____

Print Patient Name:_____ Witness:_____

Patient SS #_____ Date of Birth:_____

Patient Address:_____

_____

Print name of person signing for the patient and their relationship to the patient:

Name:_____ Date:_____

Please send requested information to:_____

_____

Phone #_____ Fax #_____