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AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient's Name: _____

Date of Birth: _____ SS#: _____

Previous Name: _____

I request and authorize: Name: _____

Address: _____

City, State, Zip: _____

Phone# _____ Fax# _____

To release health care information of the above named patient to:

Name: _____

Address: _____

City, State, Zip: _____

Phone# _____ Fax# _____

This request and authorization applies to:

____ Health care information relating to the following treatment, condition, or date of treatment:

____ All health care information _____ Other: _____

I understand that my express consent is required to release health care information relating to testing, diagnosis, and/or treatment for HIV/AIDS Virus, sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing or treatment.

Signature: _____ Date: _____

Witness: _____ Date: _____

This release of information will expire one (1) year from the above date patient or responsible party signature was obtained. This release of information may expire sooner, if date is specified here: _____