Authorization To Release Medical Information

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Patient's Name:________________________________ Birthdate:_____/_____/_______

Social Security Number:______-____-______ Maiden Name:______________________

Phone Number: (_______) ________ - ____________

All Records ( ) Lab ( ) X-Rays ( ) Other ( )_____________________

I hereby authorize Dr.__________________________ to release / obtain the information

contained in my medical records to / from ____________________________________ .

Address:_______________________ City:________________ State: _____ Zip_______

Phone Number: (_____) _______ - ____________ Fax: (_____) _______ - ___________

I understand that my records may contain information regarding the diagnosis or treatment of sexually transmitted diseases, drug and/or alcohol, mental illness, psychiatric treatment, or AIDS virus. I give my permission for these records to be released.

Signature:_________________________________ Date:_________________________