AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient's name:_____Date of Birth_____

SSN:_____Previous name:_____

I request and authorize_____to release health care information of the patient named above to:

Name: _____

Address: _____

City,State: _____Zip code_____

This request and authorization applies to:

_____ Health care information relating to the following treatment, condition or dates of treatment.

_____

_____ All health care information

_____ Other:_____

I understand that my express consent is required to release any 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. If I have been tested, diagnosed, or treated 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.

_____Date_____
Signature of patient or patient's authorized representative

_____
Relationship or status if signed by anyone other than patient(parent, legal guardian, personal representative, etc.)

This authorization expires 90 days after the date it is signed.