

**Authorization for Release of Medical Information**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

I, \_\_\_\_\_  
(patient's name) hereby authorize the release of medical information **TO:**

Doctor/Clinic/Hospital: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone: \_\_\_\_\_ Fax : \_\_\_\_\_

**FROM:**

Doctor/Clinic/Hospital: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone: \_\_\_\_\_ Fax : \_\_\_\_\_

Please release the following:

- All health information (including growth charts and vaccination records)**
- History/Physical Exam     Discharge Summary     Diagnostic Test Reports     Lab Results
- Progress Notes     Consultation Reports     Radiology/Images     Pathology Reports
- Other (specify): \_\_\_\_\_

I consent to the release of information related to HIV/AIDS or infection with any other communicable diseases and information related to behavioral or mental health services and treatment for alcohol and drug abuse, with the rest of the medical records

- Yes, I consent to the release of this information.
- No, I do not consent to the release of this information.

Purpose of disclosure:

Treatment/ Continuing medical care

I understand that I may revoke this authorization in writing at any time. Otherwise, this authorization shall remain valid until such time as it is revoked in writing.

Signature of Parent or Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Print Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_