AUTHORIZATION TO RELEASE MEDICAL INFORMATION

PATIENT INFORMATION:

NAME _____

ADDRESS _____

CITY/STATE/ZIP_____

PHONE ( ) _____ DATE OF BIRTH_____/_____/_____

I HEREBY AUTHORIZE AND REQUEST FROM:

NAME _____

ADDRESS _____

CITY/STATE/ZIP_____

PHONE ( ) _____ FAX ( ) _____

TO FURNISH MEDICAL RECORDS AND INFORMATION PERTAINING TO MY MEDICAL HISTORY, MENTAL OR PHYSICAL CONDITION, LABORATORY AND X-RAY FINDINGS, SERVICES RENDERED AND TREATMENT TO:

NAME _____

ADDRESS _____

CITY/STATE/ZIP_____

PHONE ( ) _____ FAX ( ) _____

REASON FOR RELEASE: _____

I UNDERSTAND THAT THIS AUTHORIZATION BECOMES EFFECTIVE IMMEDIATELY AND WILL REMAIN SO UNTIL REVOKED BY ME IN WRITING.

DATE: _____SIGNED: _____

WITNESS_____ RELATIONSHIP_____

I ALSO CONSENT TO THE RELEASE OF ANY AND ALL ALCOHOL AND/OR DRUG ABUSE OR PSYCHIATRIC TREATMENT RECORDS AS STATED ABOVE. I UNDERSTAND THAT SUCH INFORMATION CANNOT BE RELEASED WITHOUT MY SPECIFIC CONSENT. I UNDERSTAND THAT THIS AUTHORIZATION BECOMES EFFECTIVE IMMEDIATELY AND WILL REMAIN SO UNTIL REVOKED BY ME IN WRITING.

DATE: _____SIGNED: _____

WITNESS_____ RELATIONSHIP_____