



**Authorization for Release of Medical Information**

I, the undersigned, do hereby authorize Dr. \_\_\_\_\_ to release the information described below from the medical record of:

Patient name: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN#: \_\_\_\_\_

From Dr. \_\_\_\_\_ To Dr. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Information to be released: (Reports may include information on drug / alcohol / psychological / communicable disease treatment)

- Progress notes       Consultation       Lab/Path reports
- All medical records requested/received on my behalf from other medical providers regarding my history and treatment.
- All medical records

HIV/AIDS: I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS, if any, with the rest of my medical records. Initial \_\_\_\_\_ Date: \_\_\_\_\_  
 Dates of treatment: \_\_\_\_\_

Reason for release of information:

- Application for insurance coverage       Other (Please specify): \_\_\_\_\_
- Change of physician/Relocation

I understand that I may revoke this consent at any time except to the extent that action has already been taken in reliance on it and that in any event, this authorization expires automatically ninety (90) days from the date of signature, unless the physician prior to that date receives revocation.

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_  
Representative or person legally authorized to sign      Relationship to patient

(Office use only)

This information has been disclosed to you from records protected by Federal confidentiality (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by 42 CFR part 2. A general authorization for release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Signature of physician \_\_\_\_\_ Date \_\_\_\_\_