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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize: _____ _____
Name Phone

to disclose my individually identifiable health information as described below, which may include information concerning communicable disease such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), mental illness (except for psychotherapy notes), chemical or alcohol dependency, laboratory tests results, medical history , treatment, or any other such related information. I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and payment of my health care will not be affected if I do not sign this form.

I understand that if the recipient authorized to receive this information is not a covered entity, e.g. insurance company or health care provider, the released information may no longer be protected by federal and state privacy regulations.

Description of information to be released: (check all that apply)

__ Face sheet
__Discharge summary
__History & Physical
__Consultation Reports
__Operative Reports
__Radiology Reports
__Laboratory Reports
__Pathology Reports
__Diagnostic Reports
__Billing records
__Emergency Room
__Other_____
_____

I request that the information described herein be sent to the following entity:

_____ _____
Name Address

_____ _____
Phone Fax

I understand that this authorization will expire in 1 year from the date of this authorization unless I otherwise specify.

_____ _____ _____
Printed Name***** Date of Birth**** Date****

_____ _____
Signature****** Relationship to Patient****

In order to obtain any medical records or release to any doctor or to your insurance, we need this form left blank and just filled out where the asterisks***** are.