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AUTHORIZATION FOR RELEASE/REQUEST OF INFORMATION

PATIENT INFORMATION:

DATE:	**DOB:**
PATIENTS NAME (PLEASE PRINT):	
STREET ADDRESS:	
CITY/STATE/ZIP CODE:	**PHONE NUMBER:**

RELEASE MEDICAL RECORDS TO:
ADDRESS OF RECIPIENT:
CITY/STATE/ZIP CODE:

MAIL(**Out of State Only**) **PICK UP**

INFORMATION REQUEST:

ALL MEDICAL RECORDS
RECORDS PERTAINING TO SPECIFIC DATE OF SERVICE: From__________To__________
IMMUNIZATION RECORDS
OTHER: ___________________________

REASON FOR TRANSFER:

RELOCATION
CHANGE OF INSURANCE: __________________________
DISSATISFACTION OFFICE OR MEDICAL CARE
OTHER: (PLEASE SPECIFY) _________________________

SIGNATURE: ____ **DATE:**_____________
(of patient or legal guardian, if patient is a minor. Patients 18 years and older must sign for themselves).

HIGHLY CONFIDENTIAL INFORMATION:

SIGNATURE: ____ **DATE:**_____________
By signing my name I authorize the release of all highly confidential information including Mental Illness or Developmental Disability, HIV/AIDS test results and Substance (drug or alcohol) Abuse.

AUTHORIZATION IS VALID FOR ONE YEAR, UNLESS REVOKED BY THE PATIENT.