______________________________ ______________________________
Patient full name (Please Print) Date of Birth

______________________________ ______________________________
Street address Social Security Number

______________________________ ______________________________
City/State/Zip Code Phone Number

At the request of the individual, I ______________________________, do hereby

Authorize ______________________________ to release:

____Discharge Summary ____Pathology Reports ____Other
____History and Physical ____Laboratory Reports ______________________
____Progress Notes ____Radiology Reports ______________________
____Operative Notes ____Emergency Reports

____I Do ____I Do Not authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse

INFORMATION RELEASE TO:

____
Name of Company/Agency/Facility/Person

____
Street Address

____
City/State/Zip Code

PURPOSE OF DISCLOSURE:
____Referral to Specialist ____Insurance ____Workers Comp
____Legal Investigation ____Disability Determination ____Personal
____Change of Doctor ____Continuing Care
Other (Please Specify) ______________________________

Please provide the best telephone number in the event we need to contact you:______________________

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but it will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would the no longer be protected by federal regulations. I understand that the medical provider to whom this authorizations is furnished may not condition its treatment of me on whether or not I sign the authorization.

______________________________ ______________________
Signature of individual or guardian or Personal Date

Representative of patient's estate

NOTE: There may be a charge fro a personal copy or the permanent transfer of your records as follows: A $10 base fee, $.50 per page for pages 1-50, then $.25 for any pages over 50.