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AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

_____
Patient

xxx / xx / _____ _____ / _____ / _____
SSN DOB

I, _____,

authorize _____

to release any and all of my medical records to:

_____

_____

_____

Specific records being requested: _____

_____

The release also specifically allows the release of any record of treatment for

- Drug and/or alcohol dependency or abuse;
- Any record of mental health treatment;
- Any record of testing, care, treatment, reporting or research, pertaining to infection with HIV or related diseases.

This release is effective for 6 months from the date of execution; however, it may be revoked by me at any time by providing notice in writing to the above named party.

Signature _____ _____
Patient or Legal Guardian Date

Witness Signature _____