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AUTHORIZATION FOR RELEASE OF INFORMATION

I_____authorize_____
(Name of patient, parent, guardian, or authorized person) (Name of physician/organization)

_____to release the medical record of _____
(Address of physician/organization) (Print patient's name)

whose birth date is _____/_____/_____and social security number is _____/____/_____ to

_____.
(Name and address of physician/organization)

This information is being requested for the purpose of _____.

RECORDS TO BE DISCLOSED

Please initial Part 1 or Part 2. For a **complete** release of records, please initial Part 1. For a **partial** release of records, initial Part 2 and note any exceptions.

Part 1_____ All medical records, **including** records concerning any mental health and developmental
(Initial) disabilities, alcohol and drug abuse records and HIV testing.

Part 2_____ All medical records **excluding** information pertaining to:
(Initial)

___ Mental health and developmental disabilities____Alcohol and drug abuse records ____ HIV testing
(Initial) (Initial) (Initial)

DISCLOSURE INFORMATION

I understand that my records are protected under law and cannot be disclosed without my written permission unless otherwise provided by statues or regulations. I have the right to revoke this consent by written statement at any time prior to release. I understand that I have the right to inspect and copy the information to be disclosed, although in certain instances there may be restrictions on this right. No information released shall be given to other individuals or agencies.

Patient's Signature_____ **Date**_____

Parent/Legal Guardian_____ **Date**_____