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MEDICAL RECORDS RELEASE FORM

Please print. All blank on this form must be completed for this release to be valid.

(1)Patient Name:_____ Any other names used:_____
(2) Date of Birth: _____Social Security #_____Phone #_____
(3) Facility/Person to Release Records:
Name:_____
Address:_____
Phone:_____
Fax:_____

(4) Facility/Person to Receive Records:
Name:_____
Address:_____
Phone:_____
Fax:_____

(5) Please release the following information:

_____Progress Notes
_____History/Physical
_____HIV Related Information
_____Immunizations
_____Problem List
_____Prenatal Care (Antepartum Care, Delivery, etc)
_____Family Planning Related Information
_____Radiology/EKG Reports
_____Health Education Related Information
_____Mental Health, Drug Related Information
_____Labs:_____
_____Other:_____

If only specific dates of service are needed, please specify:_____

(6) Purpose for Release:

_____Continued Care
_____Attorney/Legal**
_____Personal use**
_____Insurance**
_____Other:**_____

HIV/AIDS: I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records.
Initial:_____ Date:_____

This consent with expire ninety (90) days from the date of my signature, unless otherwise specified. I understand that I may revoke this authorization, except for action already taken in good faith, at any time. I further understand that the information released is for the purpose stated above and that nay other use of this information without the written consent of the patient is strictly prohibited.

(8) _____ _____
Patient or authorized Legal representative signature Relationship

(9)_____ _____
Witness Date