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I hereby authorize you to release my medical records. I understand my records may include information relating to alcohol or drug abuse, communicable diseases, HIV testing and results and psychiatric or Psychological conditions.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO:

PH: _____ FX: _____

RECORDS TO BE RELEASED: _____

PATIENT INFORMATION:

Patient Name (Print) _____

Social Security# _____ Date of Birth: _____

(Patient's Signature)

(Date)

(Witness Signature)

(Date)

If you have provided us with your permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already provided to you. This consent and authorization expires in one year from the date signed.