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Authorization to Release Medical Records/Information

I hereby authorize:						
Thereby dutilonize.	(Name of Physician, Hosp	(Name of Physician, Hospital or Healthcare Provider)				
	(Street Address, City, Star	te, Zip Code)	(Phone/Fax)			
To Furnish to:	(Name of Requestor)					
	(Street Address, City, Star	te, Zip Code)	(Phone/Fax)			
The following inform	ation contained in the patient i	records of:				
Patient Name:		Address:				
DOB:						
	All fields must be co	mpleted in order for a	uthorization to be valid			
	_No The entire medical record juired immune deficiency syndi	_	information, alcoholism and drug	; abuse information		
To be disclo	sed, the following items must	specifically be checked:				
Me	ntal Health Records	Alcoholism Reco	rds			
Dru	ig Abuse Records	HIV/Acquired In	mune Deficiency Syndrome (AIDS	S) Records		
Oth	er/Specific Information:					
I understand that I m 12 months after the o		any time and that unless a	n earlier date is specified it will au	utomatically expire		
		Guardian autho	rized to sign for patient (print):			
Patients Name (Print)	Print Name				
Patients Signature		 Signature				
Date:		Relationship:	Date:			