AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This authorization allows the healthcare provider(s) named below to release confidential medical information and records. Note: *Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.*

AUTHORIZATION

I hereby authorize:_____ to release information on
Physician/Healthcare Facility
_____(Patient's Name)_____(Patient's DOB) regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records including those from my other health care providers that the above named health care provider may hold, by means of mail, fax, or other electronic methods.

To: _____
Physician/Healthcare Facility

_____
Address City State Zip

The medical information/records will be used for the following purpose:

_____

This authorization is:

[ ] Unlimited (all records, excluding Substance Abuse, Mental Health, HIV Diagnosis/Treatment)
[ ] Limited to the following medical information: _____

_____

I also consent to the specific release of the following records:

Drug/Alcohol/Substance Abuse _____(initial)
Psychiatric/Mental Health _____(initial)
Tests for Antibodies to HIV _____(initial)
HIV Diagnosis/Treatment _____(initial)
Genetic Information _____(initial)

DURATION:

This authorization shall be effective immediately and remain in effect

until_____.

RESTRICTIONS

Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

A photocopy of facsimile of this authorization shall be considered as effective and valid as the original.

I have been advised of my right to receive a copy of this authorization.

_____	_____
Patient Signature or *legal representative*	Relationship *if other than*
_____	_____
Patient's Name (PRINT)	Date
_____	_____
Patient's Social Security Number	Patient's Date of Birth
_____	_____
Witness name	Witness signature