AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

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1. I, ________________________________, hereby authorize ____
(name, address, phone or fax)
to release health information.

2. The following information to be disclosed.

   a. Only most recent records Specific dates to be released ____________ to ____________
   b. All medical records
   c. Lab work only
   d. Hospital records
   e. CT Scans / X-rays / MRI / etc.
   f. Other ____

   For the purpose of ____

   ____

3. I understand that signing this form will authorize the release of sensitive information (including psychiatric care, HIV/AIDS, or treatment of alcohol / substance abuse). I also fully understand that only information relevant to the requester's need (diagnostic / treatment for physicians, processing of claim / pay of patient bill, etc.) will be released unless disclosure otherwise is permitted by law.

4. I do not object to this information being transmitted through mail, fax or modem.

5. I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reference to this authorization. Unless otherwise revoked. THIS AUTHORIZATION WILL EXPIRE 6 MONTHS FROM THE DATE OF THE SIGNATURE.

   Patient Name: _______________________________________ Date of Birth: __________________________

   SSN (Social Security Number): ____________________________________

   Signature of Patient: _____________________________________ Date: _____________________________

   I confirm that I am legally authorized to speak in the patient's behalf regarding disclosure of medical information regarding this patient.

   ____ Date: _____________________________
   Parent / Legal Guardian / Authorized Representative

   ____ Date: _____________________________
   Relationship to Patient

   ____ Date: _____________________________
   Witness to Signature