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AUTHORIZATION FOR TRANSFER/RELEASE OF HEALTH INFORMATION

I, (Patient Name) _____ (Date of Birth) _____

Authorize Records From:

To Disclose To:

(Name) _____ (Name) _____

(Address) _____ (Address) _____

(City, State, Zip) _____ (City, State, Zip) _____

(Phone and Fax #) _____ (Phone and Fax #) _____

_____ **On Site Review of the above patient's health records.**

_____ **I hereby authorize the release of information for the above patient's health care records.**

This disclosure is being made for the following purpose(s):

___ Continuing Care ___ Transfer of Care ___ Attorney/Court Case ___ Insurance Carrier Request
___ Workman's Compensation ___ Personal Reasons ___ Other _____

This authorization for disclosure of information is effective for one year from the date signed. This informed consent is subject to revocation at any time by written notification only.,

Patient Signature _____ **Date** _____

Or Signature of Legal Representative _____ **Date** _____

Relationship to Patient _____

This medical record may contain information about drug abuse, alcoholism, alcohol abuse, venereal disease, abortion, or mental health treatment. A separate consent must be given before this information can be released.

___ **I DO** consent to have this information disclosed. ___ Not applicable.

___ **I DO NOT** consent to have this information disclosed.

Signature of Patient or Legal Guardian _____ **Date** _____

This medical record may contain information concerning HIV testing and/or AIDS diagnosis treatment. A separate consent must be given before this information can be released.

___ **I DO** consent to have this information disclosed. ___ Not Applicable.

___ **I DO NOT** consent to have this information disclosed.

THIS AUTHORIZATION EXPIRES: Date _____

Signature of Patient or Legal Guardian _____ **Date** _____