

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Physician/Facility _____

Address _____

I, _____, authorize and
(Print Full Name)

request the release of the following medical information:

Complete Progress Notes Lab Tests
(including HIV results)

Other _____

Date of Birth: ____/____/____ Social Security # ____-____-____

Reason for Release of Information: _____

Please send records to: _____

Address _____

Signature _____ Date ____/____/____

Witness _____ Date ____/____/____

Prohibition on disclosure: This information is being disclosed to you from confidential records. As their confidentiality is protected by law, you are prohibited from making further disclosure of this information.