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## RELEASE OF MEDICAL INFORMATION

I, \_\_\_\_\_, hereby authorize \_\_\_\_\_  
(Patient)

To release copies of medical records and other information concerning my diagnosis and treatment, including but not limited to information concerning treatment of drug or alcohol abuse, alcoholism, drug related conditions HIV testing or treatment of HIV related conditions, psychiatric/psychological conditions. Review of records is also authorized.

The following information may be released or reviewed:

- Case Summary
- Doctors Orders and Progress Notes
- Immunization Records
- History and Physical Exam
- Other \_\_\_\_\_
- Lab Work
- X-ray Reports & Other Testing
- Chart problem list
- Consultations

Purpose For Disclosure: **On Going Medical Care**

The above information is to be released to: \_\_\_\_\_.

### REDISCLOSURE IS PROHIBITED WITHOUT SPECIFIC CONSENT OF THE PERSON TO WHOM IT PERTAINS.

This statement must be signed and dated and may be revoked at any time to the extent action has been taken prior to revocation. This consent will expire sixty (60) days after the date below, or sooner by choice, in which case this consent will expire on: \_\_\_\_\_.

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Today's Date

\_\_\_\_\_  
Other person legally authorized to give consent

\_\_\_\_\_  
Birth Date

\_\_\_\_\_  
Relationship to patient and reason

**This information is being disclosed to the above individual/organization for the above stated purpose from records whose confidentiality may be protected by Federal Law.**