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MEDICAL RECORDS REQUEST

I hereby authorize and request you to release medical information to:

_____
_____
_____
_____

In addition to the general authorization to release records to the person(s) or entities listed above, I authorize the release of the records described as the following:

___ Yes ___No COMMUNICABLE DISEASE-RELATED INFORMATION, INCLUDING RECORDS OF TESTING, DIAGNOSIS, OR TREATMENT OF HIV, HIV-RELATED ILLNESS, AIDS, AIDS-RELATED DISEASE

___Yes ___No DRUG AND ALCOHOL TREATMENT

___Yes ___No PSYCHOLOGICAL/PSYCHIATRIC INFORMATION, INCLUDING DIAGNOSIS AND TREATMENT

___Yes ___No PATHOLOGY SLIDES, X-RAYS, VIDEOTAPES, PHOTOGRAPHS

___Yes ___No GENETIC SCREENING

Information to be released: (Please check all that apply including specific date range) This authorization will expire _____ or upon 1 year from date of execution and the undersigned may revoke this authorization in writing.

_____ Entire Medical Record
_____ Hospital Stay/Discharge/Operative Report
_____ Immunizations
_____ Lab &/or Pathology Report(s)
_____ Prior Delivery
_____ Other

_____ Name: _____ (D.O.B.) _____
Address:
,

Reason for Request: [ ] Moved [ ] Transferring care to another Physician

[ ] Referral [ ] for own use

Signature: _____ Date: _____
Patient / Guardian

Witness: _____ Date: _____

BE ADVISED: $15 Fee required for any records to be mailed. Amount due upon request