

AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

Patient Name		Date of Birth		
Address			Telephone	
Covering the period(s) of health care:		1		
From (date)	To (date)_	, and		
Information to be disclosed (check as ma	ny as appropriate):		
Complete health record(s), OR				
ONLY:				
History & Physical Examinations	_	_Progress (Visit) Notes	Billing/Financial	
Consultation Reports	<u></u>	_Laboratory Tests		
X-Ray Reports		_Photos, Tapes, X-Rays or A	any Images	
(Initials) I specifically cops	sent to the release	of any information related to	testing and treatment for H	
AIDS, mental health/psychiatric care, or	alcohol and/or dr	ug abuse if such is contained	in the medical records. TH	
PROVISION MUST BE INITIALED BY	PERSON GIVII	NG CONSENT OR THIS IN	ORMATION WILL NOT I	
RELEASED.				
This information is to be disclosed to (na	ime & address)	Information disclosed	by (name & address)	
				
for the purpose(s) of:				
for the purpose(s) of:				
for the purpose(s) of: At the reque	est of the individu	al	, or.	
for the purpose(s) of: At the reque I understand this authorization may be re	est of the individu	al any time, except to the ext	or. or.	
for the purpose(s) of: At the reque I understand this authorization may be re reliance on this authorization. Unless of	est of the individu	al any time, except to the ext	or. or. ent that action has been take	
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