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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient's Name: _____ Birthdate: _____

Address: _____

City/State/Zip: _____

Phone Number: _____ Social Security No.: _____

I hereby authorize: _____

Address: _____

To release a copy of my medical records to:

Address: _____

For the purpose of : _____

Please send the following specific information concerning my illness and/or treatment: (Specify date of treatment)

This consent is subject to revocation at any time except to the extent that action has been taken in reliance on it. In any event, this consent automatically expires 90 days from the date of execution hereof.

I UNDERSTAND THAT MY RECORDS MAY CONTAIN INFORMATION REGARDING THE DIAGNOSIS OR TREATMENT OF HIV (AIDS VIRUS), OTHER SEXUALLY TRANSMITTED DISEASES, DRUG AND/OR ALCOHOL ABUSE, MENTAL ILLNESS, OR PSYCHIATRIC TREATMENT.

I GIVE MY SPECIFIC AUTHORIZATION FOR THESE RECORDS TO BE RELEASED.

Patient's Signature: _____ Date: _____

Parent or Legal Guardian: _____

Witness: _____ Date: _____

Please send all authorizations to:

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