Authorization to Transfer Medical Records

Authorization

I hereby authorize _____ to release any and all medical records, including but not limited to hospitalization for diagnosis and/or treatment of psychiatric and/or mental condition, alcoholism, drug abuse and/or HIV test results, AIDS, or AIDS related conditions.

Release to: Physician Name:_____
Practice: _____
Address:_____
City: _____ State: _____ ZIP: _____

Uses

The purpose of the release of this information is:

□ Continuity of Medical Care

□ Other (Specify) _____

Restrictions

The recipient should not further disclose medical information unless a valid authorization is obtained or unless such use or disclosure is specifically required or permitted by law.

Duration

This authorization will expire 60 days from today or at an earlier date, at my election (To cancel this authorization prior to the above limit, notification must be sent to the Medical Record Department in writing and bear the patient's or legal representative's signature).

Patient Information (Please print)

Patient's Name:_____

Date of Birth:_____Social Security #:_____Date(s) of Treatment: _____

Signatures

Patient's Signature:_____Date:_____

Legal Representative's Signature:_____Date:_____

Witness Signature:_____Date:_____