

I, \_\_\_\_\_, hereby authorize  
\_\_\_\_\_ to disclose the following information from the health records of:

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Covering the period(s) of health care:

From: \_\_\_\_\_ to \_\_\_\_\_

The information to be disclosed:

- |  |   |
|--|---|
| <input type="checkbox"/> <b>Complete Health Record</b>                         | <input type="checkbox"/> Consultation Report      |
| <input type="checkbox"/> Inpatient Records                                     | <input type="checkbox"/> Operative Reports        |
| <input type="checkbox"/> History and Physical Examination/<br>Progress Reports | <input type="checkbox"/> Laboratory/X-ray Reports |

I understand that this will include information relating to (check if applicable):

- AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus)
- Psychiatric care
- Treatment for alcohol and/or drug abuse

This information is to be disclosed for the purpose of \_\_\_\_\_

and is to be sent to: \_\_\_\_\_

\_\_\_\_\_

I understand that this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance upon this authorization. The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Date