AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This authorization allows the healthcare provider(s) named below to release confidential medical information and records. Note: *Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.*

AUTHORIZATION

I hereby authorize: _____
                        Physician/Healthcare Facility

To release information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records including those from my other health care providers that the above named health care provider may hold, by means of mail, fax, or other electronic methods.

To: _____
            Name

            _____
            Address

            _____   _____   _____
            City   State   Zip Code

The medical information/records will be used for the following purpose: _____

This authorization is:
    [   ] Unlimited (all records, excluding Substance Abuse, Mental Health, HIV Diagnosis/Treatment)
    [   ] Limited to the following medical information: _____

    I also consent to the specific release of the following records:

    Drug/Alcohol/Substance Abuse_____(initial)   HIV Diagnosis/Treatment _____(initial)

    Psychiatric/Mental Health   _____(initial)   Genetic Information   _____(initial)

    Tests for Antibodies to HIV   _____(initial)

DURATION   This authorization shall be effective immediately and remain in effect until_____
                                                                                    Date

RESTRICTIONS

Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

A photocopy of facsimile of this authorization shall be considered as effective and valid as the original.

I have been advised of my right to receive a copy of this authorization.

_____   _____
Signature of patient *or legal/personal representative*   Relationship *if other than patient*

_____   _____
Patient's Name (PRINT)   Date

_____   _____
Patient's Social Security Number   Patient's Date of Birth

_____   _____
Witness name   Witness signature