MEDICAL RECORDS RELEASE FORM

Patient's Name: _____ Date of Birth: _____

Social Security #: _____

Reason for Request: _____

RELEASE FROM	Doctor Name:	RELEASE TO	Doctor Name:
	Address:		Address:
	Phone:		Phone:
	Fax:		Fax:

General Information Requested

- ❑ Complete Record
- ❑ Labs
- ❑ Other _____

I request and authorize the release of information to individual named above. I understand that the information to be released may include the following condition(s):

1. Drug abuse / Alcohol abuse (federal regulation 42 C.F.R., Part 2)
2. Psychological/Psychiatric conditions
3. A test for H.I.V. (A.I.D.S.) virus
4. An A.I.D.S. diagnosis and or A.I.D.S. related condition(s).

_____ _____

Signature Date Signed

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