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MEDICAL RECORDS RELEASE

Patient Name: _____

DOB: _____

I, the undersigned, authorize the release of any and all medical information pertaining to me that are in your possession for the purpose of medical treatment. Including but not limited to HIV test results and AIDS information, psychological, psychiatric, alcohol and drug abuse, vocational records.

I further authorize that a copy of this medical authorization may be used in lieu of the original. I also understand that I can revoke this authorization at any time by writing to the health care provider, but that revoking this authorization will not affect disclosures made or actions taken before the revocation is received.

X_____

Sign Patient or Representative Date

_____

Name of Patient or Representative (Print)

_____

Relationship to Patient

Records Authorized to release: _____

Please specify

Please release my records to:

_____

_____

_____

_____