



**Authorization and Consent for Release of Medical Records
to include previous medical office**

I, the signed patient or legal guardian of patient authorization

(Name of Physician, Medical Practice, or Treating Hospital)

(Address of Facility)

(Fax # - Very Important)

(City)

(State)

(Zip)

(Telephone #)

To release medical information listed below from the records of:

(Name of Patient)

For the following dates of hospitalization and/or outpatient services:

I understand that this authorization includes release of all medical records including HIV records, Psychiatric Mental Illness, Drug/Alcohol abuse records, Venereal Disease and any other statutory protected diseases. This authorization and consent will expire ninety (90) days following the date signed. I understand that I may revoke this authorization and consent at any time expect that action has previously taken in reliance hereof.

(Signature of Patient/Guardian)

(Date of Signature)

(Print Name)

(Date of Birth) (SS#)

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