



Medical Records Release Authorization

Patients Full Name _____

Address _____ City _____ St _____ Zip _____

SSN _____ DOB _____

I hereby authorize

To release the following ___ any and all medical records ___ operative report
___ recent PAP results ___ recent lab results
___ office visit for (date) _____ ___ other _____

To _____

This information is released for ___ treatment ___ payment ___ other _____

You have the right to request that the disclosure of Protected Health Information (PHI) be restricted.

___ Check here if your are making such a request and specify all restrictions below.

This authorization becomes effective immediately and shall remain in effect until further notice or as specified

I understand that the information released could contain reference to or results of HIV Antibody (AIDS) testing, drug, alcohol, and/ or mental health information.

Signature of Responsible Party _____

Relationship _____ Date _____