Authorization to Transfer Records

I hereby authorize:

Doctor's Name/Office _____

Address _____ City _____ State _____

Phone Number _____ Fax Number _____

to release any information contained in the below named patient's medical record, with no limitations. This authorization includes release of information for psychiatric/psychological illness, alcohol and/or drug abuse, drug-related conditions, alcoholism, HIV test results and/or diagnosis/treatment of AIDS or AIDS-related conditions for:

Patient Name	Date of Birth	Signature or Guardian	Date

The following information is to be sent to the address below (please check the information below):

_____ Copy Entire Record
_____ Face Sheet/Demographics
_____ History and Physical
_____ Discharge Summary
_____ Emergency Department Records
_____ Laboratory/Pathology/Radiology Reports
_____ Operative Report
_____ Consultation(s)
_____ Progress Notes
_____ Other (please specify) _____
_____

This information is to be released to:

Doctor's Name/Office _____

Address _____ City _____ State _____

Phone Number _____ Fax Number _____

A photocopy of this authorization is to be accepted the same as the original. This consent expires sixty (60) days from the date of signature and is subject to revocation by the patient at any time prior to the expiration date except to the extent that action has been taken.

I hereby state that I have read and fully understand the above statements as they apply to the named patient(s). I hereby consent to the release of medical information with my signature(s) above.

Any further disclosure of this information is prohibited unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as permitted by law.