Consent To Release Information

Patient_____ **DOB**_____

Physician Releasing Records: **Physician/person to Receive records:**

Name:_____ **Name:**_____

Address:_____ **Address:**_____

City/State/Zip:_____ **Phone/Fax:**_____

Medical Information To Be Sent:

____ Entire medical record, INCLUDING information related to the treatment for substance abuse or dependency, psychiatric or mental health treatment, information related to testing or treatment of sexually transmitted diseases, hepatitis and HIV?AIDS.

____ Entire medical records, EXCLUDING information related to the treatment for substance abuse or dependency, psychiatric or mental health treatment, information related to testing or treatment of sexually transmitted diseases, hepatitis and HIV?AIDS.

____ Records of care from ____ to ____, INCLUDING information related to the treatment for substance abuse or dependency, psychiatric or mental health treatment, information related to testing or treatment of sexually transmitted diseases, hepatitis and HIV?AIDS.

____ Records of care from ____ to ____, EXCLUDING information related to the treatment for substance abuse or dependency, psychiatric or mental health treatment, information related to testing or treatment of sexually transmitted diseases, hepatitis and HIV?AIDS.

If deemed necessary by DR. _____, I authorize this information to be sent via fax transmission.

This release applies to all information in my medical record protected under the regulations in 42 Code of Federal Regulations Part 2.

I authorize medical information to be released as indicated above. I understand that I may revoke my consent at any time by providing written consent to the above named party. I understand that there may be a charge involved when copies are requested.

_____ _____

Patient or Legal Guardian Date

_____ _____

Witness Date