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CONSENT TO RELEASE MEDICAL INFORMATION

Patient_____ **Birthdate** _____

Physician releasing records:
Name_____
Address _____
City _____
Phone _____
Fax#_____

Physician/person to receive records:
Name_____
Address_____
City _____
Phone _____
Fax# _____

Records requested for
___ Transfer of care
___ Continuation of care
___ Moving out of area

Medical information to be sent:
_____Medical Record, INCLUDING information related to the treatment for the substance abuse or dependency; psychiatric or mental health treatment; information related to testing or treatment of sexually transmitted diseases and HIV/AIDS.

_____Entire Medical Record, 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 and HIV/AIDS.

_____Record 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 and HIV/AIDS.

_____Record of care from_____to_____EXCLUDING information related to the treatment for substance abuse or dependency; psychiatric or mental health treatment; information related to testing treatment of sexually transmitted diseases and HIV/AIDS.

If deemed necessary by Doctor_____, I authorize this information to be sent via Fax transmission.

This 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 this release is effective until _____, but that I may revoke my consent at any time by providing written consent to the above named party.

_____ _____
Patient or Patient's Legal Guardian **Date**

_____ _____
Witness **Date**