Authorization for Release of Medical Records

Patient Name: _____

Date of Birth: _____

Address: _____

Requesting Records from: _____

_____

Phone:_____ Fax: _____

I authorize you to furnish to:_____

_____

Fax:_____ all medical records and other documentation in your possession regarding (patient name): _____

I understand these records may contain information from other health care providers, as well as information which is administrative in nature. *I specifically consent to the release of any information contained in the medical record which may relate to infection with Human Immunodeficiency Virus (HIV), AIDS, or related conditions.*

I understand that you have no responsibility for the use of distribution of this information by the party to whom it is released. I release you from all liability which may arise from your compliance with this request to release records.

I authorize you to transmit this information by facsimile transmission (FAX), and release you from any liability for breach of confidentiality, misdirection of transmission or failure to receive transmission if my records are transmitted by fax.

_____ _____

Patient/Legal representative signature Date

Witness: _____

If not signed by patient, list relationship of legal representative here:

_____