

CONSENT FOR RELEASE OF MEDICAL RECORDS

Patient's name \_\_\_\_\_

Date of Birth \_\_\_\_\_ SSN \_\_\_\_\_

Address \_\_\_\_\_

Date(s) requested \_\_\_\_\_

I authorize:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

To release my medical records to:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

HIV test results will not be sent unless specifically requested:

\_\_\_\_ Yes, forward HIV test results    \_\_\_\_ DO NOT forward HIV test results

Signature \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Witness \_\_\_\_\_