AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

1. I hereby authorize (DOCTOR'S NAME) ____
to disclose the following information from the health record of:

Patient Name: ____DOB:_______________________
Reason for record release: ____
Previous Doctor's Address:
____
____
Telephone: ____ Fax: ____________________________________

Covering the period(s) of health care:
From (date) _____________________________ to (date) ____

2. Information to be disclosed:

_____ Complete Health record
_____ History & Physical
_____ Consultation Reports
_____ X-Ray Reports
_____ Discharge Summary
_____ Progress Notes
_____ Laboratory Test
_____ STD Information
_____ Other: ____

3. This information is to be disclosed to:
New Doctor's Address:
____
____
Telephone: ____ Fax: ____________________________________

4. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

____ Date: __________________________
(Parent or Legal Representative)

____ Date: __________________________
(Signature of Witness)