

**AUTHORIZATION FOR USE AND DISCLOSURE
OF MEDICAL INFORMATION**

This authorization allows the healthcare provider(s) named below to release confidential medical information and records. Note: Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse has special rules that apply and require specific authorization.

AUTHORIZATION

I hereby authorize: _____
Physician/Healthcare Facility

to release information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis, or prognosis, including x-rays, correspondence and/or medical records by means of mail, fax or other electronic methods.

TO: _____
Name

Address

City/State/Zip

USES:

This authorization is
{ } Unlimited medical information
{ } Limited to the following medical information:

DURATION: This authorization shall be effective immediately and will remain in effect until: _____(Date)

Signature of Patient (or Legal Guardian) Relationship

Patient's Name (Please Print) Date of Birth SSN

Date