# Authorization to Release Medical Information

The execution of this form does not authorize the release of information other than that specifically described below.

**To** _____

**Patient**_____

**Date of Birth** _____

**Release to** _____

I request and authorize the above named doctor or health care provider to release the information specified below to the organization, agency, or individual named in this request. I understand that there may be a fee(s) involved and they have been explained to me. I understand that the information to be released includes information regarding the following condition(s) (if any): Drug Abuse, AIDS or HIV status, alcoholism or alcohol abuse, psychological or psychiatric condition.

Information requested:

_____ Summary of Medical Treatment
_____ Copy of most recent xrays
_____ Treatment Recommendations
_____ List of medications and frequency

Purpose or need for which information is to be transferred:
_____ Insurance changed
_____ Moving out of area
_____ Second Opinion
_____ Other, specify:_____

**Authorization**: I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. Without my express revocation, this consent will automatically expire upon satisfaction of the need for this disclosure.
A copy of this authorization, and my signature thereon may be used with the same effectiveness as an original.

Signature _____ Date _____

----------office use only----------

Date Completed:_____ approval:_____