**AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION**

***REQUESTED BY:***

*Patient Name (Please Print) Date of Birth*

( )

*Address (Street, City, State, Zip) Phone*

*I request the following health information be provided:*

**Complete Medical Record**

**Other:**

***REQUESTED FROM:***

*Physician/Facility Phone*

*Address (Street, City, State, Zip) Fax*

***Please contact me if there is a charge for this service and/or when records are ready for delivery.***

***I, the undersigned, authorize the disclosure/ copying and transfer of the above named patient’s protected health information.***

*Signature of Patient / Legal Guardian / Legal Representative Date*

*Name of Parent, Legal Guardian / Legal Representative (Please Print) Relationship to Patient*

***I, the undersigned, authorize disclosure/ coping and transfer of information relating to psychiatric condition(s), alcohol and/or drug abuse, and HIV/AIDS in accordance with Federal confidentiality rules.***

*Signature of Patient / Legal Guardian / Legal Representative Date*