MEDICAL RELEASE FORM

Patient Name:_____ **Patient DOB:**_____/_____/_____

Patient Address:_____ **Patient Phone:( )**_____-_____

You are hereby authorized to disclose my Protected Health Information whether oral, written or electronic healthcare information pertaining to my complete medical record, including but not limited to HIV and AIDS confidential information. You are hereby authorized to disclose my Protected Health Information, drug and alcohol abuse and treatment information. You are hereby authorized to disclose such Protected Information to any physician, healthcare provider, or healthcare facility that has provided health care services to me. Additionally, you are hereby authorized to disclose such Protected Healthcare Information to any attorney at law representing such physician, healthcare provider or healthcare facility. Discussions related to my care. You are hereby authorized to discuss my care and treatment with any attorney or healthcare facility, or healthcare entity. This authorization expires one (1) year after execution date below.

Patient Rights:

I understand I do not have to sign this authorization to receive healthcare benefits (treatment, payment or enrollment) from the person(s) to whom this authorization is directed. I may revoke this authorization in writing at any time. If I do so, it will not affect any actions already taken by someone in reliance in this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance coverage. If I choose to revoke this authorization, I shall do so by sending a letter to the person(s) to whom this authorization is directed. Once the healthcare provider discloses information any person or organization that receives may re-disclose it.

_____ **Date:**_____

Patient or Legally Authorized Individual Signature

_____

Relationship of signing individual (self, parent, legal guardian, ect.)

Protected Health Information is requested From:

Company:_____ **Phone: ( )**_____-_____

Address:_____ **Fax: ( )**_____-_____

_____

Protected Health Information is Requested To:

Company:_____ **Phone: ( )**_____-_____

Address:_____ **Fax: ( )**_____-_____

Circle One: W.Cook, M.D. M. Ralsten, M.D . N.Quinn, M.D . M.Carter, M.D. L.Pichardo, M.D.

( ) Transfer Care ( )Out of town move ( )Consult Mailed/Faxed on _____Initials:____