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**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 have special rules that require specific authorization.*

**AUTHORIZATION**

I hereby authorize: \_\_\_\_\_  
Physician/Healthcare Facility

To release information on \_\_\_\_\_ (Patient's Name)  
\_\_\_\_\_ (Patient's DOB) regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records including those from my other health care providers that the above named health care provider may hold, by means of mail, fax, or other electronic methods.

To: \_\_\_\_\_  
Name  
\_\_\_\_\_  
Address  
\_\_\_\_\_  
City State Zip Code

The medical information/records will be used for the following purpose:  
\_\_\_\_\_

This authorization is:

Unlimited (all records, excluding Substance Abuse, Mental Health, HIV Diagnosis/Treatment)

Limited to the following medical information:

\_\_\_\_\_  
\_\_\_\_\_

I also consent to the specific release of the following records:

Drug/Alcohol/Substance Abuse \_\_\_\_\_(initial)  
Psychiatric/Mental Health \_\_\_\_\_(initial)  
Tests for Antibodies to HIV \_\_\_\_\_(initial)  
HIV Diagnosis/Treatment \_\_\_\_\_(initial)  
Genetic Information \_\_\_\_\_(initial)

DURATION

This authorization shall be effective immediately and remain in effect until \_\_\_\_\_(expiration date) or for one year from the date of signature if not dated

RESTRICTIONS

Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

A photocopy of facsimile of this authorization shall be considered as effective and valid as the original.

I have been advised of my right to receive a copy of this authorization.

\_\_\_\_\_  
Signature of patient *or legal/personal representative*

\_\_\_\_\_  
Relationship *if other than patient*

\_\_\_\_\_  
Patient's Name (PRINT)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Social Security Number

\_\_\_\_\_  
Patient's Date of Birth

\_\_\_\_\_  
Witness name

\_\_\_\_\_  
Witness signature