Authorization to Release Medical Information



**OR**

**(select one)**

**Please send my medical records/films to:**



Return to:



**Return to:**

**-OR-**

**Protected or Sensitive information:**

**BY INITIALING**

DRUG ABUSE DIAGNOSIS/TREATMENT ALCOHOLISM DIAGNOSIS/TREATMENT MENTAL HEALTH/TREATMENT

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SEXUALLY TRANSMITTED DISEASES

AIDS/HIV TEST RESULTS INCLUDING RELATED HIGH RISK BEHAVIOR GENETIC TESTING

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Signature of Patient or Legally Responsible Person Relationship to Patient Date

