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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, _____, agree to release my medical records from (party sending records):

_____

_____

To, (the party that is to receive the records):

_____

_____

This information is being disclosed for the following purpose(s) of:

_____

_____

I understand that this information may contain information relating to: (check if applicable)

____ Acquired Immunodeficiency Syndrome (AIDS) or infection with HIV (Human Immunodeficiency Virus)

____ Mental Health

____ Alcohol and/or Drug Abuse

_____ _____

(DATE) **(PATIENT SIGNATURE)**

_____ _____

(DATE) **(LEGAL GUARDIAN, IF PATIENT IS UNDER 18)**

_____ _____

(DATE) **(WITNESS SIGNATURE)**