

**RELEASE OF MEDICAL RECORDS CONSENT FORM**

Copy to be Placed in Patient's Chart.....

**RECORDS TO BE RELEASED FROM:**\_\_\_\_\_

ADDRESS:\_\_\_\_\_

\_\_\_\_\_

ALL RECORDS... YES \_\_\_\_\_ SELECTED PERIOD OF TIME \_\_\_\_\_

**PLEASE FORWARD A COPY OF MY MEDICAL RECORDS TO:**

PERSON TO SEND TO:\_\_\_\_\_

ADDRESS:\_\_\_\_\_

\_\_\_\_\_

PATIENT'S NAME \_\_\_\_\_

**PATIENT'S SIGNATURE** \_\_\_\_\_

I understand that the information in my medical record may include information relating to treatment of drug or alcohol abuse, sickle cell anemia, psychological or psychiatric impairments, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC) and/or human immunodeficiency virus (HIV).

RESPONSIBLE PARTY'S SIGNATURE \_\_\_\_\_

PATIENT'S DATE OF BIRTH \_\_\_\_\_

PATIENT'S ADDRESS: \_\_\_\_\_

\_\_\_\_\_