AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient's name:_____ Date of birth:_____

SSN:_____ Previous name:_____

I request and authorize _____ to release health care information of the patient named above to:

Name:_____

Address:_____

City, State:_____ Zip code:_____

Institutional Affiliation:_____

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed, or treated for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing, or treatment.

_____

Signature of patient or patient's authorized representative Date signed

_____

Relationship or status if signed by anyone other than patient (parent, legal guardian, personal representative, etc.)

THIS AUTHORIZATION EXPIRES 90 DAYS AFTER THE DATE IT IS SIGNED