| Patient Name: (Please Print) | |
|------------------------------|---------------|
| Date of Birth: | Phone Number: |

| Name: Address: Oty, State, Zp: Fax: | | Name: Address: Oty, State, Zp: Fax: |
|--|---|--|
| 0 0 0 0 0 | All medical records on file Records dating fromto Recent pap smear and birth control records (i Laboratory/X-Rays from date Immunization Record Other (Please specify) | including labs, cytology) |
| 0 0 0 0 | Drug or alcohol treatment/Abuse (Federal Regulation 42 C.F.R. Part 2) Psychological or psychiatric conditions HIV Antibodies Hepatitis B | Sgnature: Sgnature: Sgnature: Sgnature: |
| 0 0 0 | Other provider(s) continuing care or Insurance/ Payer claim Other (Please specify) | ○ Legal action ○ Moving ○ School |

I certify that this request has been made voluntarily. This authorization may be revoked at any time, except to the extent that action has already been taken to comply with it. Authorization expires ninety (90) days from the date of signature. I release the above named persons, institutions or health centers from liability and claims of any nature pertaining to this disclosure of information contained in my medical records.

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

| Date | Sgnature of patient |
|--|-------------------------------------|
| Witness Sgnature | Sgnature of Legal Guardian/Executor |
| If patient is unable to sign, document reason: | |
| Sent | Ву |