AUTHORIZATION to RELEASE MEDICAL RECORDS/INFORMATION

Physician or facility to provide records:_____

Facility Address:_____Phone_____

Patient's name:_____

Street:_____City:_____State:_____Zip Code:_____

Social Security #:_____DOB_____

Person to receive records (name and address): DO NOT FAX RECORDS!!

Dr. Alan P. Aboaf
Dr. T. Scott Gilmer
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I authorize the health care provider to release the information specified below to the organization, agency, or individual named on this request. I specifically authorize the release of information regarding the following condition(s):

Initials

_____ Drug abuse if any

_____ Psychological or psychiatric conditions if any

Initials

_____ Substance abuse if any

_____ AIDS/HIV if any

Release these records: DO NOT FAX RECORDS!

Initials

1. Only records generated by this facility (not including records received from other sources).....____
2. Only some portion of records maintained at facility (specify below).....____
3. All medical records at this facility.....____

_____

_____

Expiration or revocation of authorization-I understand that I may revoke this authorization at any time.

Use of copies-A copy of this authorization may be utilized with the same effectiveness as an original.

Patient name (print):

_____

Person authorized to sign for patient:

_____

SIGNATURE

Patient's signature:

_____ Date:_____