Consent for the Release of Confidential Medical Records

Patient Name: _____ DOB: _____

Address: _____

_____

I _____ do authorize _____

to disclose to _____ the following information:

(Circle one or write in as you prefer)

My entire medical chart	Doctors notes	Laboratory Studies
X-ray, MRI, CT Studies	Hospital & Surgery notes	Consultation notes

*** THE INFORMATION, WHICH I AUTHORIZE FOR RELEASE, MAY INCLUDE INFORMATION THAT MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR VENEREAL DISEASE THAT MAY INCLUDE, BUT IS NOT LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA, AND THE HUMAN IMMUNODEFICIENCY VIRUS, ALSO KNOWN AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS).***

I understand that my records are protected under the federal and state confidentiality regulations and cannot be released without my written consent unless otherwise provided for in said regulations.

Further disclosure of information in records released pursuant to this consent is prohibited without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. I also understand that I may revoke this consent in writing at any time, unless action has already been taken based on it. I further acknowledge that the information to be released was fully explained to me and that this consent is given of my own free will.

_____ _____

Signature of Patient or Guardian Signature of Witness

Signed this _____ day of _____, 20_____.