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AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security # _____

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

Name: _____

Address: _____

Phone: _____ Fax: _____

This request and authorization applies to:

I All health care information

I Other: _____

I understand that my express written consent is required to release any health care information relating to testing, diagnosis and/or treatment of many disorders including HIV (AIDS virus), sexually transmitted diseases, psychiatric discords/mental health, or drug and/or alcohol use. I give specific authorization to release all records to the above named individual or facility by mail or facsimile transmission. **This authorization expires 90 days after the signed date.**

Patient Signature: _____ **Date:** _____

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