AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize	, M.D. to furnish medical information (patient) to
(name and address of person to receive re	ecords).
· · · · · · · · · · · · · · · · · · ·	ng but not limited to mental health records protected alcohol abuse records and/or HIV test results, if any,
	ving purposes:*
This authorization is effective now and will remain	ain in effect until (date).
I understand that I have the right to receive a cop	by of this authorization.
Signed:	Dated:
Print Name:	
[] guardian or conservator of an incompete[] beneficiary or personal representative of	ne extent minor could not have consented to the care) ent patient deceased patient ** (where information solely for purpose of processing
*Signed: Treating Physician	Dated:
HIV test results, a separate authorization is requested Act often requires that both patient's treating photographic information may be released.	Lanterman-Petris-Short Act (LPS) or (2) containing aired for each separate disclosure. Further, the LPS aysician and the patient sign the authorization form and representative of a deceased patient can obtain

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