Authorization to Release Medical Records

Dear ________________________________:

This letter will authorize you to provide a copy of my medical records to ____________

_____________________________. At this time I am requesting the following:

____________ Complete record.

____________ Records of care from __________ to ____________ only.

____________ Records of care concerning the following condition(s) _____________

____.

____________ Other. Specify: ____.

____________ Confer with other person orally about information in my medical record.

HIV/AIDS. I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS, or infection with any other causeative agent of AIDS, with the rest of my medical records.

Initial: _______ Date: _______________

Please release the information to:

____

____

____

The reasons or purposes for this release of information are:

Transfer medical records to ________________________________.

I understand that you will provide this information within 15 business days from receipt of this request.

Signed: ____ Date: ____________
(Patient or person legally authorized to consent on patient's behalf)

Print Patient's Name & DOB: ____