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MEDICAL RECORDS RELEASE FORM

Name:_______________________________________ **DOB:** ___________

Address:____

I hereby authorize/request that a copy of:

_____ **My medical record**, including information related to the treatment for substance abuse or dependency, psychiatric or mental health treatment, information related to testing or treatment of sexually transmitted diseases and HIV/AIDS.

_____ **Record of care from** ___________ to __________ including information related to treatment of substance abuse or dependency, psychiatric or mental health treatment, information related to testing or treatment of sexually transmitted disease and HIV/AIDS.

_____ **X-Rays**

_____ **Other:**____

Released From:

____

Released To:

____

____

____ ________________

Patient Signature **Date**