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I HEREBY AUTHORIZE AND REQUEST THE RELEASE OF RECORDS

FROM:____
DOCTOR OR HOSPITAL

____
ADDRESS

THE COMPLETE MEDICAL RECORDS IN YOUR POSSESSION, CONCERNING MY ILLNESS AND/OR TREATMENT DURING THE PERIOD
FROM______________________________TO ______________________________
I UNDERSTAND THAT THE INFORMATION TO BE RELEASED MAY INCLUDE INFORMATION REGARDING THE FOLLOWING CONDITIONS:
DRUG ABUSE, ALCOHOLISM/ALCOHOL ABUSE, TESTING FOR OR INFECTION WITH HUMAN IMMUNODEFICIENCY (HIV) VIRUS, SICKLE CELL ANEMIA

TO:
____

____

NAME_________________________________DOB: ____________DATE__________

ADDRESS____

SIGNATURE____
(IF RELATIVE, STATE RELATIONSHIP)

WITNESS____