AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

FROM:

_____ _____
(Name of Provider) (Provider Phone Number)

_____ _____
(Provider Address) (Provider Fax Number)

TO:

_____ _____
(Name of Provider) (Provider Phone Number)

_____ _____
(Provider Address) (Provider Fax Number)

For the health records of:

_____ _____
(Print Full Legal Name) (Date of Birth)

_____ _____
(Street Address) (Home Phone Number)

_____ _____
(City, State, Zip Code) (Work Phone Number)

- Complete Health Record
- Spectacle Prescription
- Contact Lens Prescription
- Other: _____

This form authorizes release of medical information including HIV-related information. You may choose to release just your non-HIV medical information, or both your HIV-related and medical information. Your information may be protected from disclosure by federal privacy law and state law. Confidential HIV-related information is any information indicating that a person has had an HIV-related test or has HIV infection, HIV-related illness or AIDS, or any information that could indicate a person has been potentially exposed to HIV.

____ I do _____I do not authorize the release of information related to HIV / AIDS.

I certify that this request has been made voluntarily, and this authorization will expire one year from the signed date:

_____ _____
(Patient Printed Electronic Signature) (Date signed)