

Authorization for Release of My Medical Information

I hereby authorize you to discuss with and/or release information to the following persons(s):

The information you may discuss or release is:

- Care and Condition
- Test Results
- Psychological/mental health/psychiatric information
- Diagnosis or treatment of alcoholism
- Drug abuse or dependency
- HIV (AIDS) testing and/or treatment
- Pick up prescriptions
- Pick up drug samples
- Pick up forms
- Insurance Information

This document shall remain in effect until it is resolved by my written notification:

Patient's Name: _____

Date of Birth: _____

Signature: _____ Date _____

Witness: _____ Date _____