MDY PRIMARY CARE MEDICINE, P.L.
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AUTHORIZATION FOR RELEASE OF CONFIDENTIAL MEDICAL INFORMATION

Records being requested from or released to: _____
(Circle one) (name of facility/provider)

address of above facility: _____

City/State/Zip Code: _____

Phone# _____ Fax# _____

PATIENT'S NAME: _____
(last) (first) (middle/maiden)

PATIENT'S SOCIAL SECURITY NUMBER: _____

PATIENT'S DATE OF BIRTH: _____

NOTE: PATIENT OR REPRESENTATIVE MUST INITIAL APPLICABLE AREAS FOR RELEASE:

To release all Psychiatric/psychological information* _____(Initials)
Alcohol and/or drug/ chemical information* _____(Initials)
HIV tests and info pertaining to these tests or to treatment in connection with these tests _____ (Initials)

Date records requested: _____ Signature: _____

**If the patient is 12 to 17 years old, the parent and patient must sign for release of info.*

Witness: _____ Date_____

NOTE TO RECEIVING PARTY: This information is disclosed to you form records whose confidentiality is protected by law. Any redisclosure is strictly prohibited without the written permission of the patient/client/legal representative identified above.

Note: If more than 10 pages please do not fax unless specified