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Authorization for Release of Medical Records

I Authorize: ____
____
____
____

To release medical record and/or information to:
____
____
____

including HIV testing, mental health and/or substance abuse services. I further release the above doctors from all legal responsibility and/or liability that may arise from the release of such records a specified about and I waive all rights I have to preserve their confidentiality.

Pathology Report(s) _____ *Operative Report(s)* _____ *Progress note(s)* ______

Complete Health records _____ *Laboratory test(s)* ____________

Patient's legal name: ____

*Date of Birth:*____

Patient Signature: ____

*Date:*_________________________