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RECORDS RELEASE AUTHORIZATION

Patient's Name _____ Maiden Name _____

Address _____ Birthdate _____ Soc Sec # _____

Area Code – Telephone Number _____

I authorize Dr Donald Blitz, Dr Leslie Lafer, Dr Robin Blumer
to:

_____**Release to** _____

_____

_____**Obtain from**_____

_____

Information contained in the medical records of the patient identified above. I authorize release of drug, chemical dependency, alcohol abuse, mental health and other records in accordance with Federal Regulations. NOTE: I expressly authorize information concerning the following serious communicable disease to be released including HIV infection, AIDS Related Complex (ARC), Acquired Immunodeficiency Syndrome (AIDS).

_____All

_____Other:_____

This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42 CFR Part 2 and Public Act 258) prohibit from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

Patient or Patient Representative Signature _____ Witness _____

Relationship if other than Patient _____ Date _____