CONSENT FOR RELEASE OF INFORMATON

1. I hereby authorize _____
   Address: _____
   Phone: _____Fax_____

   To release the following information from the health records of:

   Patient's Name: _____
   Date of Birth: _____SS#_____

   Covering the period(s) of treatment from _____to_____

2. Information to be released to:

   _____History & Physical
   _____Films/Slides
   _____Operative Records
   _____Complete health records
   _____Billing records
   _____Other_____

3. Information is to be released to:

   Name: _____
   Address: _____
   City: _____

4. Purpose of Disclosure:_____

5. I understand this consent can be revoked at any time except to the extent that disclosure of information has already occurred prior to receipt of the revocation by the office. If revocation is not received, authorization will be considered valid for a period of time not to exceed one year.

6. Date this consent expires:_____

7. The facility, its employees and attending physicians are released from legal responsibility or liability for the release of the above information to the extent indicated and authorization herein.

8. I understand that the information released could contain reference to or results of HIV antibody (AIDS) testing.

SIGNATURE:_____ DATE:_____

Relation to the Patient:_____