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TO: _____

AUTHORIZATION FOR MEDICAL RECORD RELEASE

NAME OF PATIENT: _____

DATE OF BIRTH: _____

I hereby authorize release of medical records including the following information:

_____ HIV RECORDS
_____ DRUG/ALCOHOL USE RECORDS
_____ MENTAL HEALTH RECORDS

_____ SEND RECORDS FOR DATE OF SERVICE _____ THRU _____

_____ SEND RECORDS FOR ALL DATES OF SERVICE

SEND MEDICAL RECORDS TO: _____

PATIENT/GUARDIAN SIGNATURE: _____

DATE: _____