Aseptic Primary & Family Practice Clinic LLC

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PATIENT NAME _____
Last Name First Name Middle Initial

HOME ADDRESS _____
Street Address

_____
State City Zip Code

_____
Date of Birth

I hereby Request _____

_____
Street Address

_____
State City Zip Code

_____
Phone Number Fax Number

To furnish a copy of ALL Available Medical Records of the patient named above in Progressive Medical Clinic.

Purpose or Need for Discloser: Continued Patient Care

_____ I authorize the release of all information, including information recording HIV testing AIDS information

Initials substance abuse, alcohol use, psychiatric disorders and psychological disorder that may be included in my medical record. I hereby release your physician and staff from liability following this authorization and release.

Signature of Patient/Parent/Conservator/Guardian	Authority Relationship to Patient
Witness Signature	Date