Ric Minudri, MD
Huong Trinh, MD
Nigel Campbell, MD
Theresa Myers, MD
Julie Waite, A.R.N.P.

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient's Name ______________________ Date of Birth: ______________________

Current Address: ______________________

SSN: ______________________ Previous Name: ______________________

I request and authorize

Name ______________________

Address ______________________ Phone Number ______________________

City, State, ZIP ______________________ Fax Number ______________________

To release health care information of the patient names above to:

Name ______________________

Address ______________________ Phone Number ______________________

City, State, ZIP ______________________ Fax Number ______________________

Date records are needed by: ______________________ OK to Fax (circle one) YES NO

This request and authorization applies to:

____ All Health Care Information
____ Health Care information relating to the following treatment, condition or dates of treatment: ____________
____
____ Other

Reason for requesting records

____ Changing Physicians
____ Leaving the area
____ Consultation with a Specialist
____ Request from school or college or employer
____ Request from insurance company

I understand that my expressed consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV(AIDS Virus), sexually transmitted diseases or infections. psychiatric disorders, mental health, or drug and/or alcohol use. If I have been tested, diagnosed, and or treated for HIV(AIDS Virus), sexually transmitted diseases or infections. psychiatric disorders, mental health, or drug and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis testing or treatment.

______________________ ______________________
Signature of patient or patient's authorized representative Date Signed

____
Relationship or status if signed by anyone other than the patient
(parent, legal guardian, personal representative, etc.)

Authorization expires 90 days after the date it is signed

MEDICAL REQUEST FOR RECORDS WILL BE COMPLETED IN 14 WORKING DAYS