AUTHORIZATION TO RELEASE MEDICAL RECORDS

I, _____ (patient name), hereinafter "releaser", hereby authorize The Office of Quito Osuna Carr, M.D. & Associates to release any and all medical records including, but not limited to, psychological, psychiatric, alcohol and drug treatment records and laboratory reports including HIV testing data to:

Name of Medical Facility: _____

Address: _____

_____

Phone: _____ **Fax:**_____

This authority to release includes, but is not limited to: medical reports, clinical and nurse's notes, history of injury, subjective and objective complaints, x-rays, interpretation of a diagnostic test, (including a copy of the report), diagnosis and prognosis; if applicable, emergency room records or logs, physical examination reports, laboratory reports, tissue committee reports, operative reports and logs, progress notes, doctors orders, physical therapy records, admission and discharge summary reports and all outpatient records, and any other document, records or information in your possession relative to my past, present, or future physical and mental condition.

IN ADDITION, IT IS SPECIFICALLY ACKNOWLEDGED BY RELEASER THAT SUCH RECORDS MAY INCLUDE AND/OR CONTAIN REFERENCE TO ANY OR ALL OF THE FOLLOWING SUBJECTS, AND RELEASER, BY HIS/HER INTIALS APPEARING HEREIN BELOW, NONETHELESS DIRECTS THAT ALL OF THE FOLLOWING MATERIALS ALSO BE RELEASED AS SPECIFED HEREIN:

Any and all medical records, reports, documents, or materials in any way:

A) To the drug, alcohol, or substance abuse history, if any of RELEASER _____ (patient initials)
B) To the emotional, mental health, or psychiatric condition, if any of RELEASER _____ (patient initials)
C) To the HIV, or AIDS infection or testing, if any of RELEASER _____ (patient initials)

The information which relates to section C is to be released under section 24-2B-7 and this authorization to release the information to the above mentioned is subject to the following statement: This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making further disclosure of such information without written consent of the person to whom the information pertains or is otherwise permitted by state law.

A photocopy of this authorization, which contains my signature, shall be considered as effective and valid as the original and shall be honored by those to whom it is provided for up to 1 (one) year after date signed.

Date Signed: _____ _____
RELEASER'S SIGNATURE

Witnessed By:_____

_____
Faxed By: _____ **PATIENT'S DATE OF BIRTH**

Date Faxed: _____ _____
PATIENT'S SOCIAL SECURITY NO.

Patient leaving practice? _____ Yes _____ No

*** If specific records or date range of records are being requested please attach a separate sheet with regards to the specifics.**