Your Hospital's Logo Here

Street Address
City, State Zip
(202) 555 - 1212

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

PATIENT (Print):	NAME AT TIME OF TREATMENT (If Different):
STREET ADDRESS:	DATE OF BIRTH:
CITY:	SOCIAL SECURITY #:
STATE: ZIP:	TELEPHONE #:

I AUTHORIZE:

_____
HOSPITAL -OR- PHYSICIAN'S OFFICE ADDRESS

TO RELEASE TO YOUR HOSPITAL (Washington, DC):

_____ _____ _____
NURSING UNIT TELEPHONE # FACIMILE #

INFORMATION CONTAINED IN MY MEDICAL RECORD FOR THE PURPOSE OF CONTINUING CARE, AS I AM CURRENTLY HOSPITALIZED.

☐ The following treatment date(s) only: _____ to _____
ADMISSION DISCHARGE

If no dates are listed above, send all records.

By signing this authorization, I agree that all medical records or other information regarding my treatment, hospitalization and/or outpatient care for any condition, including psychological or psychiatric impairment, substance abuse, alcoholism, Acquired Immunodeficiency Syndrome (AIDS), tests for Human Immunodeficiency Virus (HIV), sexually transmitted diseases, sexual assault and criminal cases and photographs may be released, unless unless specific "treatment date(s)" or "specific information: is checked above. **I understand that I am entitled to inspect my record and to revoke my consent in writing where applicable.**

_____ _____
SIGNATURE of PATIENT / PARENT / GUARDIAN / AUTHORIZED REPRESENTATIVE DATE

_____
RELATIONSHIP TO PATIENT

This authorization will expire 6 months from date of signature:

_____

_____

ANY REDISCLOSURE OF INFORMATION BY RECIPIENTS IS PROHIBITED BY LAW