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AUTHORIZATION FOR RELEASE OF INFORMATION

Date: _____

I hereby authorize _____ to release the following information from the medical record(s) of:

_____ _____
Patient's Name (PRINT) Social Security #

_____ _____
Address Date of Birth

Covering the periods of care from _____ to _____

Information to be released:

_____ Physician's Notes _____ Exclude HIV Test Reports

_____ Nurse's Notes _____ Exclude Drug/Alcohol Notes

_____ Lab Reports _____ Entire Chart

Information is to be released to: _____

Purpose for release of this information: _____

_____

I understand that this consent can be REVOKED at any time except to the extent that disclosure made in good faith has already occurred in reliance of this consent. This consent is otherwise valid for ninety (90) days from the signature date.

Dr. Krueger and her employees are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

I further authorize that a photocopy of this authorization form is fully acceptable as an original.

_____ _____
Signature of Patient Date

_____
Witness