

***A Association of
S Specialty
P Physicians, Inc.***

Name & Address where this goes:

NAME: _____

(patient)

SOCIAL SECURITY #: _____ BIRTHDATE: _____

I, THE UNDERSIGNED, HEREBY AUTHORIZE _____

TO PROVIDE _____

WITH THE FOLLOWING INFORMATION:

_____ ENTIRE RECORD _____ OTHER:

FROM THE FOLLOWING DATES OF SERVICE/TREATMENT: _____

PURPOSE OF DISCLOSURE: _____

I understand that my medical record may contain information related to:

- *Acquired immunodeficiency Syndrome (AIDS) or infection with HIV*
- *Psychiatric care*
- *Treatment for alcohol and/or drug abuse*

I GIVE CONSENT FOR RELEASE OF THIS INFORMATION:

_____ DATE: _____

I DO NOT GIVE CONSENT FOR RELEASE OF THIS INFORMATION:

_____ DATE: _____

This authorization for release of information is valid for 90 days from the date of signature, unless revoked by written notice to the providing institution, provided the notice is received prior to the release of information.

_____ DATE: _____
(signature parent/guardian) RELATIONSHIP: _____

_____ DATE: _____
(signature of witness)