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I HEREBY AUTHORIZE AND REQUEST THE RELEASE OF RECORDS

FROM: _____
DOCTOR OR HOSPITAL

ADDRESS

THE COMPLETE MEDICAL RECORDS IN YOUR POSSESSION, CONCERNING MY
ILLNESS AND/OR TREATMENT DURING THE PERIOD
FROM _____ TO _____

I UNDERSTAND THAT THE INFORMATION TO BE RELEASED MAY INCLUDE
INFORMATION REGARDING THE FOLLOWING CONDITIONS:
DRUG ABUSE, ALCOHOLISM/ALCOHOL ABUSE, TESTING FOR OR INFECTION WITH
HUMAN IMMUNODEFICIENCY (HIV) VIRUS, SICKLE CELL ANEMIA

TO:

NAME _____ DOB: _____ DATE _____

ADDRESS _____

SIGNATURE _____
(IF RELATIVE, STATE RELATIONSHIP)

WITNESS _____