Authorization for Release of Medical Records

I, the undersigned patient/guardian hereby authorize Dr. James D. Ellner to release information listed below from the records of ____

Date of Birth: ________________________________

The release of information to which I consent is for the purpose of continuity of care.

For the followings date of care or outpatient services:

____ all dates of service

____ specific dates of service

____ copy for patient

Please be advised that this is your personal copy of your records. Only one copy of records will be provided per year without charge. ____ Initialed by patient.

Records sent to: ____

Address: ____

Phone:________________________________ Fax: ____________________________

I understand this authorization includes release of all medical records including HIV records, Psychiatric Mental Illness, Drug/Alcohol abuse records, Venereal Disease and any other statutory protected diseases. This authorization and consent will expire ninety (90) days following the date signed. I understand that I may revoke this authorization and consent at any time except to the extent that action has previously taken in reliance hereof.

____	_____________________________
Signature of Patient/Guardian	**Date of Signature**
____	_____________________________
Relationship to Patient	**Signature of Witness**

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