# RELEASE OF MEDICAL RECORDS

**I hereby authorize use or disclosure of protected health information including notes and test results about me as described below.**

**TO [ ]　　　FROM [ ]**

**Tom Sloan, M.D.**
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**TO [ ]　　　FROM [ ]**

**Doctor/Facility:**______________________________________________________

**Address:**__________________________________________________________

**City, State:**________________________________________________________

**Phone:**______________________________**Fax:**____________________________

Please release:

[ ] medical records from ____________to ____________
[ ] test results ___________________________________
[ ] other ______________________________________

[ ] HIV testing, treatment of AIDS, AIDS related conditions, drug or alcohol abuse, drug related conditions, alcoholism, and psychiatric or psychological conditions require additional authorization to be released. If you wish this type of information to be released (release good for 30 days), sign here:_____________________Date:________

**Purpose of disclosure: Medical Treatment**

This signed authorization expires in 30 days or I understand that I may revoke the authorization at any time by notifying the office in writing. However, I understand that if I revoke authorization, any action already taken in advance of this cannot be reversed, and my revocation will not affect those actions.

I understand that the information used or disclosed may be subject to re-disclosure by the person or facility receiving it, and would then no longer be protected by federal privacy regulations.

THIS FORM MUST BE FULLY COMPLETED

Patient Signature:______________________ DOB:_________________

Printed Name:_________________________ SS#:__________________

Patient Address:_____________________________________________

Today's Date:__________________________