



MEDICAL ACCESS

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MEDICAL RECORDS RELEASE/DISCLOSURE OF INFORMATION (ALLOWS MEDICAL ACCESS TO RELEASE RECORDS)

I, _____, hereby authorize and request
Medical Access to release a copy of my medical records to the following:

Name: _____

Address: _____

City: _____ State _____ Zip: _____

Phone: _____ Fax: _____

This should include records for the following:

() Any and all information related to past and present medical histories,
diagnoses, and treatment.

() Medical records concerning the following date(s) of services: _____

I understand that the medical records to be released may contain information
related to my HIV status, AIDS, Sexually Transmitted Diseases, alcohol
and/or drug use, or mental health services, and I hereby authorize release of
this information as well. This authorization is valid for a period of one (1)
year from the date below and may be withdrawn by me at anytime.

(Signature)

(Date)