melmed center
TM

Authorization for Release/Disclosure of Records/Information

Patient's name: _____ Birth date: _____

Address: _____ City: _____ State: _____ Zip: _____

I hereby authorize the release/request of copies and/or discussion of the specified information included in my medical records that are in your possession. **I understand that record requests may take up to 10 business days to process. Furthermore, I understand that if my request lacks any of the information requested below, the processing time may be significantly delayed.**

Unless specified otherwise, this information may include records on chromosome analysis, drug and alcohol abuse, sickle cell anemia, HIV infection, AIDS, or tests for HIV infections. **Initial:**_____
Specific information to be released:

_____

_____

The purpose of this disclosure is (Check appropriate box):
( ) Continuity of treatment services
( ) Other (Specify):_____

( ) Release of information from Melmed Center/ To

_____
Name of Person/ Agency/ Institution

_____
Address

_____
City State Zip Telephone number Fax number

( ) Request information to be released to Melmed Center/ From

_____
Name of Person/ Agency/ Institution

_____
Address

_____
City State Zip Telephone number Fax number

I certify that this request has been made voluntarily and that the given information above is accurate to the best of my knowledge. By my signature below, I further declare that I have the legal authority to grant the above permission. I understand that I have the right to revoke this authorization, provided that I do so in writing, except to the extent that Melmed Center has already used or disclosed the information in reliance to this authorization. This authorization will expire only upon completion of a consent revocation form.

_____ _____
Name of Patient (Please Print) Today's Date

_____ _____
Signature of Patient/Parent/Legal Guardian Relationship to Patient

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