AUTHORIZATION FOR RELEASE OF INFORMATION

PLEASE PRINT CLEARLY

Patient Name: _____

Address: _____

Phone: _____ DOB: _____ SSN: _____

I authorize _____
(Print name of Provider we will be requesting records from)
to release information from my medical record as indicated below to:

Name: MICHAEL W. JOHNSTON
Address: 7 WINDSWEEP COURT PHENIX CITY, ALABAMA 36870
Phone: 334-297-5555 Fax: 334-297-5525

INFORMATION TO BE RELEASED:

X History and Physical Exam
X Progress Notes
X Lab Reports
X X-Ray Reports
X Other: ALL RECORDS

I specifically authorize the release of information relating to:

__ *Substance abuse (including alcohol/drug abuse)*
__ *Mental Health (including psychotherapy notes)*
__ *HIV related information (AIDS related testing)*

_____
Signature of Patient or Legal Guardian

PURPOSE OF DISCLOSURE:

__ Changing Physicians
__ Legal
__ School
__ Worker's Compensation
__ Consultation/second opinion
__ Insurance
__ Continuing Care

I understand that this consent for release of medical information is subject to revocation by the undersigned at any time, except to the extent that action has already been taken in reliance thereon. Unless otherwise stated below, this consent shall automatically expire one hundred eighty (180) days from the date signed. I understand that there may be a fee for copies of my medical records.

_____ _____
Signature of Patient Date Signature of Parent/Executor/Legal Representative