



Authorization for Release of Information

By completing this form you are authorizing Pipe Trades Family Health and Wellness Center to request information from the provider below for the exclusive purpose of treating the named patient listed below.

Patient name	Previous last name (if any)	Date of birth	Phone #
Street address	City	State	Zip code

From: Clinic / Doctor

Clinic Name	Doctor	Phone #	
Street address	City	State	Zip code

TO: Clinic/Doctor:

Clinic Name	Doctor	Phone #	
Street address	City	State	Zip code

Dates of Records Requested ___ / ___ / ___ - ___ / ___ / ___	
<input type="checkbox"/> All Records	<input type="checkbox"/> Mental health records
<input type="checkbox"/> Clinic visit notes	<input type="checkbox"/> Pathology/Lab reports
<input type="checkbox"/> Radiology reports	<input type="checkbox"/> Outside clinic: _____ (Name of clinic)

This authorization will automatically expire in 12 months or _____. I understand that this authorization extends to all of any part of the records designated above, which may include psychiatric information, and/or genetic counseling/testing, and/or alcohol/drug abuse and/or AIDS (Acquired Immunodeficiency Syndrome), and/or may include the result of an HIV test or the fact that an HIV test was performed. I expressly consent to the release of information as designated above unless initialed below or otherwise required by law.

May **NOT** include information related to (please initial):

HIV/AIDS Mental Health Drug and/or Alcohol Abuse Genetic Counseling/Testing Information

I understand that this authorization is revocable upon written notice to the office where the original authorization is retained, except to the extent that action has already been taken on this authorization. I further understand I need not sign this form in order to assure treatment or payment. I understand that upon receipt, Pipe Trades Family Health and Wellness Center will use the information for continuing medical care and may release the information to other providers involved in the care. I understand there may be a charge for my records. I further authorize the above provider to release the information marked above.

Patient/Legal Representative or Parent/Legal Guardian Signature

Date