



## **PERMISSION TO RELEASE MEDICAL RECORDS**

I hereby authorize:

- |   |   |
|---|---|
| <input type="checkbox"/> James W. Faulkner, MD, FACS  | <input type="checkbox"/> David A. Guthman, MD, FACS |
| <input type="checkbox"/> Jerrold H. Seckler, MD, FACS | <input type="checkbox"/> Helen C. Ahn, MD, FACS     |

to release my medical records to the physician/provider listed below:

Patient's Physician/Provider \_\_\_\_\_

Mailing Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Telephone # \_\_\_\_\_ Fax# \_\_\_\_\_

**Including the following medical information:**

- |   |   |
|---|---|
| <input type="checkbox"/> Complete records   | <input type="checkbox"/> Radiological Reports |
| <input type="checkbox"/> Laboratory Reports |   |
| <input type="checkbox"/> Other _____        |   |

Special dates of interest \_\_\_\_\_ to \_\_\_\_\_

I understand that my express consent is required to release any healthcare information relating to test and diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders, mental health or drug and alcohol use. If I have been tested, diagnosed or treated for HIV (AIDS virus) or sexually transmitted diseases, psychiatric disorders or mental health or drug and alcohol use, you are specifically authorized to release all healthcare information relating to such diagnosis, testing or treatment.

Patient's Name

\_\_\_\_\_  
(Last) (First) (Middle Initial)

Social Security# \_\_\_\_\_ Date of Birth \_\_\_\_\_

Mailing address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

**\*There is minimum fee of \$30.00 for this service.**