Authorization for Release of Medical Records to SheDoc

I, authorize________________________ fax number: ________________to provide SheDoc with a complete copy of
(one provider)

____ _______________________ __________________________
Patient's Full Name (Please Print) Date of Birth Social Security Number

confidential medical records.

In addition to the general authorization to release records to the entity listed above, I authorize the release of the records described as the following:

- Communicable disease-related information, including records of testing, diagnosis, or treatment for HIV, HIV-related illness, AIDS, AIDS-related diseases… Yes or No.
- Drug and alcohol treatment… Yes or No.
- Psychological/psychiatric information, including diagnosis and treatment… Yes or No.

Disclosure of the information is requested for the purpose of doctor-patient relationship.

This authorization is valid for six (6) months from the date of signing and may be revoked at any time by providing written notice (USPS certified letter) of revocation. I understand I cannot revoke this authorization retroactively for information already released.

Date: _______________ Time: ___________ am/pm

____
Signature (Person authorizing release)

Relation to patient: ___________________________

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