CONSENT TO RELEASE INFORMATION FROM POPE PAUL VI INSTITUTE

Patient Name_____ Other Names Used_____

Address_____ Date of Birth_____

Phone number _____ Social Security #_____

I HEREBY AUTHORIZE POPE PAUL VI INSTITUTE TO SEND MEDICAL RECORDS TO:

Name_____ Address_____

_____

Signature of Patient or Legal Guardian Date

Medical information to be released to include the following:

- ❑ Lab Results dated _____
- ❑ Progress Notes dated_____
- ❑ Complete Medical records_____
- ❑ Other_____

_____

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

I specifically authorize the release of data and information related to:

Substance abuse (alcohol/drug abuse)	Yes _____	No_____	not applicable_____
Mental Health	Yes_____	No_____	not applicable_____
HIV-Related Information (AIDS related testing)	Yes_____	No_____	not applicable_____

_____

Signature of Patient or Legal Guardian

This authorization for release of information shall remain in effect no longer than ninety (90) days.

This information may have been disclosed to you from records whose confidentiality is protected by federal law. Federal regulation prohibits you from making any further disclosure without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

Word/consent to release informationfrom popepaul/lc/03

Records will be sent within 30 days of request.

Office use:

Copied by _____ on _____

Mailed/faxed on (date)_____

Picked up on (date)_____

BY_____