All Island Medical Associates, P.C.

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MEDICAL RECORD RELEASE

Name:_____ DOB:_____
Phone # :_____

PLEASE OBTAIN INFORMATION FROM:	PLEASE SEND INFORMATION TO:
_____	_____
Name	Name
_____	_____
Street Address	Street Address
_____	_____
City, State, Zip	City, State, Zip
Phone: _____	Phone: _____
Fax: _____	Fax: _____

I AUTHORIZE the following information to disclosed (**Please initial all that apply**)

_____ Entire Record
_____ Immunization Record
_____ Lab Reports
_____ TB Tests
_____ HIV Record
_____ STD Record
_____ Psychiatric Record
_____ Alcohol/Substance Abuse Record

REASON for disclosure of health information (**Please initial all that apply**)

_____ At my request
_____ Legal
_____ Work
_____ School
_____ Insurance

I understand that I do not have to sign this authorization to get treatment.

I understand that once my health care information is disclosed as I have authorized, it could be re-disclosed by the recipient and is no longer protected by All Island Medical Associates.

I understand that signing this authorization does not cancel any rights I have under the other state or federal laws.

_____ Date: _____
Client Signature (Parent of Legal Representative, if applicable) Relationship/Authority