Patient Information

Last: ______________________________ First: ______________________________

D.O.B: ______________ Sex: ☐ MALE ☐ FEMALE

Phone: (H) ____________________ (C) ____________________

Address: ____

☐ Give my health care information to: ☐ Get my health care information from:

Doctor/ Hospital/ ETC: ____

Address: ____

City: ____________________ State: __________ Zip: __________

Phone: ____________________ Fax: ____________________

Please release the following information (check all that applies):

☐ Laboratory Testing ☐ Radiology Testing ☐ Office Notes/ Procedures

Others (Please be specific): ____

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I ☐ DO. I ☐ DO NOT WANT ANY INFORMATION REFERRING TO HIV ANTIBODY TESTING, OR TREATMENT/ DIAGNOSIS OF AIDS RELATED DISEASE TO BE DISCLOSED.

I ☐ DO. I ☐ DO NOT WANT ANY INFORMATION REFERRING TO DIAGNOSIS OR TREATMENT OF ALCOHOL/SUBSTANCE ABUSE TO BE RELEASED. I UNDERSTAND THAT SUCH INFORMATION CANNOT BE DISCLOSED WITHOUT MY SPECIFIC CONSENT.

I ☐ DO. I ☐ DO NOT WANT ANY INFORMATION REFERRING TO DIAGNOSIS OF MENTAL HEALTH TO BE RELEASED.

I ☐ DO NOT. I ☐ DO NEED TO REVIEW THE INFORMATION BEFORE FAXING.

PATIENT SIGNATURE: ______________________________ DATE: ______________