RECORDS REQUEST AND AUTHORIZATION TO TRANSFER

Date: _____

Requesting Records From Dr: _____

Address: _____

_____

Fax: _____

I hereby authorize you to transfer medical
records to/from Dr: _____

Address: _____

_____

Fax: _____

Please mail or fax all records or reports relating to my case. These records may include information or tests relating to HIV, AIDs, mental health, and drug abuse.

Patient's Name:_____

Date of Birth:_____ Social Security Number: _____

Patient's Signature: _____