ACCESS MEDICAL CLINIC
FAMILY PRACTICE

Medical Records Release

Patient Name _____ Patient Date of Birth _____

Address _____

Street City State ZIP _____

Home phone _____ Work phone _____

Please release my medical records as follows:

From: _____ To: Access Medical Clinic

_____

_____

Records to be released (please check ALL that apply):

___ Annual exam and Pap smear / Prostate
___ Labs/X-ray
___ Birth control
___ Abortion care
___ All medical records
___ Other _____

I understand that my medical records are protected under state and federal confidentiality regulations. Disclosure of information regarding drug and/or alcohol abuse and treatment, confirmed sexually transmitted infections (including testing or treatment for HIV/AIDS), and diagnosis of mental illness or psychiatric care cannot be released without my written consent.

Please initial below if you **DO NOT** want any of the following records released. All applicable records will be released if nothing is marked.

_____ Drug and/or alcohol abuse, diagnosis or treatment
_____ HIV/AIDS testing and/or treatment
_____ Psychiatric care and/or mental illness
_____ Confirmed STI test results and/or treatment

This consent can be revoked by me at any time unless action has been taken in reliance on it.
If not previously revoked, this consent will terminate in 90 days.

_____ _____
Patient Signature Date

_____ _____
Witness Date