OUTGOING RELEASEOF MEDICAL RECORDS

I hearby authorize _____ to furnish a copy of the medical records for the past 12 months including any HIV test concerning the treatment of

_____

PATIENT NAME

_____

DATE OF BIRTH

TO: _____

MEDICAL Facility

_____

ADDRESS

_____

CITY, STATE, ZIP CODE

ATTENTION Dr. _____

I hearby release you, your physicians, and employees from liability for the following authorization and request.

AUTHORIZATION IS VALID FOR 90 SAYS FROM DATE OF SIGNATURE

_____	_____
WITNESS	**PATIENT/LEGAL GUARDIAN SIGNATURE**
_____	_____
WITNESS SIGNATURE	**PATIENT/LEGAL GUARDIAN SIGNATURE**
_____	_____
DATE	**DATE**