AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION

To: Dr. Lorna C. Wolfe

CONCERNING THE MEDICAL RECORDS OF:

_____

Patient's Date of Birth: _____ Patient's SSN: _____

I, the undersigned, hereby authorize and request Dr. Lorna C. Wolfe, to provide the following persons:

FULL NAME	Relationship to patient	Date of Birth/Maiden Name

With any information they request from my medical records or from my surgeon or other representatives from Dr. Lorna C. Wolfe. This may include copies of written report or verbal communications by phone on in person. This authorization is valid for any and all information related to medical histories, problems, diagnoses, tests and treatment of the above identified patient.

I understand that the medical information to be released may contain information related to HIV status, AIDS, hepatitis, sexually-transmitted diseases, pregnancy, alcohol or drug use, or mental health services, and I hereby authorized the release of this information.

This authorization for disclosure is valid for a period of one (1) year and may be withdrawn by me at any time, except during an action taken in response thereon.

_____

Signature of "Person of Interest" (If signer is other than patient, please print name as well.)

_____

Date signed