

BARBARA E. EVANS, M.D.
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REQUEST FOR RELEASE OF MEDICAL RECORDS

Patient's Name: _____ Birthdate: _____
Previous Name: (if applicable) _____
Address: _____
City: _____ State: _____ Zip: _____

This will authorize:

Dr. Barbara E Evans, M.D.

To release the information listed below to

Doctor's Name and Facility: _____

Address: _____

City: _____ State: _____ Zip: _____

- Medical and Exam information
- Glasses Prescription
- Contact Lens Prescription

THIS WILL AUTHORIZE FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW. I SPECIFICALLY AUTHORIZE THE RELEASE OF DATA AND INFORMATION RELATING TO:

Circle One:

- Yes or No Substance abuse (alcohol/drug use)
- Yes or No Mental Health/Depression (includes psychological testing)
- Yes or No HIV related information/AIDS testing

This authorization will automatically expire one year from the date of signature or until _____. I understand that I may revoke this consent at any time by notifying the above-named provider of information. Any release of information made prior to my revocation is in compliance with this authorization and shall not constitute a breach of my rights to confidentiality.

RESTRICTIONS: This authorization is being given with the understanding that the receiver may not further use or disclose the medical information unless another authorization is obtained from me or unless such use of disclosure is specifically required or permitted by law.

Signature of Patient or legal guardian: _____ Date _____
Relationship if not patient: _____

For office use only : Faxed to: _____ By: _____ Date: _____