

George B. Elvove, M.D., P.C.

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AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____

Phone No: _____ Email: _____

I authorize release of my medical records: [CHECK ONE ONLY]

To: George B. Elvove, M.D., P.C. at the above address, from:

Name address Fax

OR

To the following doctor/clinic: _____
Name

address Secure fax number

Please indicate all item(s) that apply:

- | | | |
|--|---|--|
| <input type="checkbox"/> Clinic Records | <input type="checkbox"/> Consultations | <input type="checkbox"/> Discharge Summary |
| <input type="checkbox"/> Lab Reports | <input type="checkbox"/> History & Physical | <input type="checkbox"/> E/R Reports |
| <input type="checkbox"/> Operative/Pathology | <input type="checkbox"/> HIV antibody Reports | <input type="checkbox"/> Imaging Reports |
| <input type="checkbox"/> Psychiatric | <input type="checkbox"/> Drug/Alcohol Abuse | <input type="checkbox"/> Entire Record |
| <input type="checkbox"/> Other _____ | | |

Approximate dates of treatment: _____

Purpose of health information to be released: _____

I understand that the information in my health record may include information relating to sexually transmitted disease, AIDS or HIV. It may also include information about behavioral or mental health services and treatment for alcohol or drug abuse. I understand that this consent is valid for 90 days from the signature date. I can revoke this authorization at anytime by giving written notice to George B. Elvove, M.D., P.C.

Signature of patient or authorized legal guardian

Date

Relationship to patient, if signed by legal representative

Witness