		* Street Address	
* City/State/Zip		* City/State/Zip	
* Telephone Number	* Fax Number	* Telephone Number	* Fax Number
* Check delivery option ❑ Paper Copy ❑ USB (if available)		Providers Fax # _____ ❑ E-Mail (encrypted) _____	

*What records do you want? (Check appropriate boxes below):

a. Date(s) of Service: ___/___/___ through ___/___/___

❑ Discharge Summary ❑ Emergency Room Records ❑ Operative/Procedure Reports ❑ Billing
❑ Test Results (X-Rays, Lab/Pathology Results) Please specify _____
❑ Other (Immunization Records, Medication List) Please specify _____

b. I specifically authorize release of the following information (check as appropriate):

❑ Mental health treatment information ___(initial) ❑ HIV test results ___(initial)
❑ Alcohol/drug treatment information ___(initial) ❑ Genetic Testing Information ___(initial)

A separate authorization is required to authorize the disclosure or use of psychotherapy as defined in the federal regulations implementing the Health Insurance Portability Accountability Act.

* For the Purpose of: ❑ Patient Request ❑ Other: _____