

**AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION
FROM KELLIWOOD FAMILY PRACTICE**

Patient Name: _____ Date of Birth: _____

Address: _____ Telephone #: _____

City State Zip: _____

I hereby authorize:

**KELLIWOOD FAMILY PRACTICE
Steven C. Spencer, MD**

to disclose information from my/my minor child's medical record to:

Name: _____

Address: _____

City, State, Zip: _____

This information is needed for the following reason:

The specific information I wish to have released is:

_____ **LAB AND DIAGNOSTIC REPORTS ONLY** _____ **IMMUNIZATION RECORDS**

_____ **ALL MEDICAL RECORDS**

I understand that I may revoke this consent at any time, except where information has already been released. This authorization is valid for one year from the date it is signed.

Signature (Parent or Legal Guardian if minor)

Date

Witness

Expiration date

This medical record may contain information about drug abuse, alcoholism, alcohol abuse, venereal disease, abortion, or mental health treatment. Separate consent must be given before this information can be released.

_____ I DO consent _____ I DO NOT consent to have this information disclosed.

Signature (Parent or Legal Guardian if minor)

Date

This medical record may contain information concerning HIV testing and/or AIDS diagnosis treatment. Separate consent must be given before this information can be released.

_____ I DO consent _____ I DO NOT consent to have this information disclosed.

Signature (Parent or Legal Guardian if minor)

Date