Bryan Davis, M.D.
FAMILY MEDICINE

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Medical Records Release

I, the undersigned, do hereby request and authorize:

Dr: _____

Address: _____

City, State, Zip: _____

Phone & Fax #: _____

To release:

_____ All information, including diagnosis and medical records of any treatment or examination rendered to me

_____ All records between _____ and _____.

For the following purpose:

__Medical Care __Legal Matter __Insurance __Other

This authorization may include release of information pertaining to:

Psychiatric Records	HIV Test Results
Drug and Alcohol Testing	AIDS Related Diagnosis

I also understand that I may revoke this consent at any time except as to the extent that action has been taken in response to such request. I understand that this form has been fully explained to me and that I have read and understand its contents. A photo static copy of this form may be used in lieu if the original.

Patient Name: _____

SS#: _____ DOB: _____

Patient/Guardian Signature: _____ Date: _____

Witness: _____ Date: _____