

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION
PLEASE PRINT CLEARLY**

Patient's Name _____

Address _____ Town _____

State _____ Zip _____ Home Phone _____

Birthdate _____

I Authorize Kevin P. McGrath, M.D. to release medical information from my medical records to:
Name of Doctor/ Hospital/ Attorney _____

Address _____

Town _____ State _____ Zip _____

For the purpose of Review/Examination, I further authorize you to provide such copies thereof as may be requested, the foregoing is subject to such limitation as indicated below: (Initial on Applicable Line(s) Below)

_____ Entire Record

_____ Specific Information _____

_____ Old Records from Previous Physician _____

I give special permission to release any information regarding:

_____ Substance Abuse _____ Psychiatric/Mental Health Information _____ HIV Information

Reason for Request _____

This Authorization will automatically expire one year from the date signed. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance thereon.

Patient/ Guardian

Date

Witness

Date

FOR OFFICE USE ONLY

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