



**IF PATIENT IS REQUESTING A FORM TO BE COMPLETED AND
THERE IS NO RELEASE OF INFORMATION SIGNED THIS
RELEASE MUST ACCOMPANY THE FORM:**

Authorization for Release of Information to: _____

I authorize Dr. Stuart D. Patterson that has provided treatment on my behalf to disclose my entire medical record and any other health information concerning me to the company named above. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

Unless limits are shown below, this form pertains to all of the records listed above.

By my signature below, I acknowledge that any agreements that I have made to restrict my protected health information do not apply to this authorization and I instruct My Provider to release and disclose my entire medical record without restriction.

_____ **Date:** _____
Patient Signature