

H Berryman Edwards, MD, FAPA

PATIENT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, _____, hereby authorize Dr. H. Berryman Edwards to release the information in my medical records, including (initial all that apply):

____ entire record

____ diagnoses

____ treatment information

____ coordination of treatment

____ other (specify): _____

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment of HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed, or treated for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, Dr. Edwards is specifically authorized to release all health care information relating to such diagnosis, testing, or treatment.

I understand that authorizing Dr. Edwards to release my medical record to a third party may result in a waiver of my privilege rights or denial of medical, life, or disability insurance and that consultation with an attorney may be advisable.

The information specified may only be released to:

I also authorize Dr. Edwards to discuss my treatment if appropriate. This released information may be used solely for medical treatment, insurance claim, or legal purposes. This authorization expires in 90 days from the date signed. It may be revoked at any time by written request.

Signed: _____ Date: _____