SunMed
PRIMARY CARE
Internal Medicine

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Please Circle the Office You Are Visiting Today

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Dear Dr._____

Patient Name:_____

DOB:_____

I _____authorize release to the attending physician any pertinent information concerning my case history, examinations, treatments, laboratory, x-rays etc., as well as psychological information and records of drug related nature. Alcohol and drug abuse information, if present, has been disclosed from records whose confidentiality is protected by federal law. Federal regulation prohibits making any further disclosure of records without specific written authorization of the undersigned, or as otherwise permitted by such regulations. The confidentiality of the HIV antibody tests results is protected by federal law which prohibits making any further disclosure of records without specific written authorization of the undersigned, or as otherwise permitted by state law. I understand that if I consent to the release of any of my medical records, the results of any HIV antibody testing are included in the medical records.

_____ _____

Patient Signature Witness Signature

_____ _____

Date Relationship to Patient