

Consent for Medical Records

Patient Name: _____ **DOB:** _____

I hereby consent and authorize *Spectrum Family Health, Inc.* to obtain / release a copy of my medical record to:

NAME OF AGENCY, FACILITY OR PRACTITIONER

STREET

CITY

STATE

ZIP

Please check one:

- All of the information in such records is to be released, including **mental illness, alcoholism, substance abuse, and sexually transmitted infection and HIV testing, if any.**
- Only the following specific information described below and contained in such records to be released:

I understand that such information will not be given, sold, transferred or in any way relayed to any other person or party not specified above without my further written consent. I understand that this consent may be withdrawn at any time prior to the release of information here authorized.

I understand that such records are needed for, or will be used for continuing care.

Signed _____ Date _____
(Patient or authorized representative) (Month/Day/Year)

Name (Print) _____ Relationship _____

Witness Name _____ Witness Sign _____