Authorization to Release Medical Records

Patient Name:______________________________________

Patient Address:_____________________________________

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Social Security #:____________________Birth Date:_______________

Date of Treatment:__________________________

I authorize, Michael B. Sytniak, Ph.D., to release all information contained in my patient records, including as applicable:

- Information about human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS) and AIDS related complex (ARC).
- Alcohol and drug abuse treatment information protected under regulations in 42 Code of Federal Regulations, Part, 2.
- Mental health treatment records, psychological services and social services information including communications made by me to Dr. Sytniak

To the individuals or organizations below, only under the conditions listed below:

1. Name and address of the receiver:____

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2. Specific type of information to be disclosed:____________________________________

3. The purpose and need for this disclosure:_______________________________________

4. This consent can be revoked at any time unless the provider has acted in reliance on its continued effectiveness. Regarding substance abuse treatment records, if any, this consent can last only long enough to reasonably accomplish its purpose.

5. Without expressed revocation this consent expires after 90 days or for the following specified reasons:____

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__________________________	________________________________
Witness by	Patient's signature
__________________________	________________________________
Date	Parent or Guardian's signature when appropriate