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Justin C.K. Davis, MD
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Authorization for Release of Medical Information

I hereby authorize the release of information from the medical record of:
Patient Name: _____ Date of Birth: _____
Social Security #: _____ Daytime Phone #: _____

Information Released To: Justin C.K. Davis, MD
From:
_____
_____
_____

Please Release the Following:

__**X**___ Problem List	_____ X-Ray Reports
__**X**___ Progress Notes	_____ X-Ray Films
__**X**___ History/Physical Exam	_____ EKG Reports
_____ Lab Reports	_____ Other Diagnostic Reports (Specify) _____
_____ Immunizations	_____ Other (Specify) _____

Including information (if applicable) pertaining to:
__**X**___ Mental Health __**X**___ Drug/Alcohol __**X**___ HIV/AIDS __**X**___ Communicable Treatment

Purpose of Need for Disclosure:

__**X**___ Continued Patient Care	_____ Personal Use
_____ Attorney/Legal	_____ Insurance Claim/Application
_____ Disability Determination	_____ Other (Specify)_____

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited. I further understand that I may revoke this consent (in writing) at any time except to the extent that action has been taken in reliance on it. This consent will expire 365 days after the date of my signature unless otherwise specified.

_____ _____
Signature of Patient or Legal Representative Date

_____
Relationship to Patient (if other than self)