Middleway Medicine

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Authorization to Disclose Medical Records

I,_____, authorize Middleway Medicine to release a copy of my medical information to the following persons or institutions (name and Address):

1)_____
2)_____
3)_____

The information will be used on my behalf for the following purposes:

_____
_____

The followed items must be individually initialed to be included in the information shared:

_____HIV/AIDS related records
_____Mental health information
_____Genetic testing information
_____Drug/alcohol diagnosis, treatment or referral information

This authorization is:

_____For any time period
_____Limited to records from the following time period_____

This authorization may be revoked at any time. Unless revoked earlier, this consent will expire is 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

_____ _____
Signature (Patient/Parent/Guardian) Date