## Release Of Medical Information

I, _________________________________, date of birth _____________________ hereby permit **Physician Care Centers.** To release any or all of my medical information, including AIDS/HIV, mental health, and alcohol/drug-related issues.
To:

**Name:** **Relationship:**

1.___________________________________________________________________________

2.___________________________________________________________________________

3.___________________________________________________________________________

4.___________________________________________________________________________

□ Progress Notes as requested
□ Labs and X-rays
□ Correspondence
□ Personal Demographics
□ Diagnosis
□ Other Information__________________________________________________________

_____________________________________ _______________________________

**Patient/Guardian Signature** **Date**

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