BENTLEY HEALTH CENTER

Consent to Release Medical Information

Patient: _____Date of Birth:_____ Grad. Mo./Yr. _____ Cell # _____

Provider releasing medical information	**Provider receiving medical information**
Name: _____	_____
Address: _____	_____
City/State: _____	_____
Phone: _____Fax:_____	_____

Medical Information to be sent, via _____ (fax) _____(mail) _____(pick-up)

____ **Immunization Record ONLY** **_____OTHER (Please Specify)**

____ Medical Record, INCLUDING information related to the treatment/use/abuse of drugs or alcohol; psychiatric or mental health treatment, sexually transmitted diseases, HIV/AIDS, sexual health, physical abuse, sexual assault and abortion.

____ Medical Record, EXCLUDING information related to the treatment/use/abuse of drugs or alcohol; psychiatric or mental health treatment, sexually transmitted diseases, HIV/AIDS, sexual health, physical abuse, sexual assault and abortion.

_____ Record of care from _____ to _____ INCLUDING information related to the treatment/use/abuse of drugs or alcohol; psychiatric or mental health treatment, sexually transmitted diseases, HIV/AIDS, sexual health, physical abuse, sexual assault and abortion.

____ Record of care from _____ to ____ ___EXCLUDING information related to the treatment/use/abuse of drugs or alcohol; psychiatric or mental health treatment, sexually transmitted diseases, HIV/AIDS, sexual health, physical abuse, sexual assault and abortion.

I authorize medical information to be released as indicated above. I understand that this release is effective for period of one (1) year from the date signed below, but that I may revoke my consent at any time by providing written consent to the above named party.

I have carefully read the above consent and will request to speak to a Nurse or Nurse Practitioner if I have any questions. I acknowledge that my record may contain sensitive health information and if it is not being directly faxed or mailed to another medical provider, I will keep it in a safe, secure location. I understand that if it is mailed to my home address, it could possibly be inadvertently viewed by household members.

_____ (Patient or Legal Guardian) _____(Date)

_____ (Witness) _____(Date)

7/11/16