CONSENT FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize ***John M. Henderson DO PC*** to release the following information. Including any treatment related to drugs or alcohol abuse, sexually transmitted diseases, psychological/psychiatric conditions, or AID/HIV condition from the medical records of:

NAME: **DOB:**

ADDRESS: **CITY/STATE/ZIP:**

INFORMATION FOR RELEASE

OFFICE NOTES: ☐ **X-RAYS:** ☐

LAB RESULTS: ☐ **PROVIDER CORRESPONDENCE:** ☐

OTHER: **ALL:** ☐

PURPOSE FOR THE RELEASE OF INFORMATION:

INFORMATION TO BE RELEASED TO:

METHOD OF RELEASE: FAX: ◯ EMAIL: ◯ MAIL: ◯

I understand the consent, except for the action already taken, can be withdrawn at any time in writing. This authorization will remain in effect for 90 days after I sign and date this form below. **Other conditions upon which this consent expires, if any:**

This facility, it's employees, and physicians are released from any legal responsibility or liability for the release of the above medical records to the extent indicated and authorized herein. I understand that this facility may charge a records fee of up to **$50.00** for my records, depending on the recipient and method of delivery.

FEES:

Patient Pick-up: Less than or equal to 50 dollars

Doctor to Doctor: No charge

Legal or Medical Requests (not delivered directly to patient): Variable

Signature: **Date:**

Relation to Patient (If not self): Father **Witness:**