GABLE HEALTH AND COUNSELING CENTER
Thirteenth & Bern Streets
P.O. Box 15234
Reading, PA 19612-5234
Telephone: 610-921-7532
Fax: 610-921-7590
www.albright.edu

AUTHORIZATION TO RELEASE MEDICAL RECORDS

To: ________________________________

Address: ____________________________

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I, ____________________________, authorize any physician, nurse, or other health professional who has attended to me, or any hospital at which I have been confined, to furnish to ____ or an authorized representative, any and all information that may be requested regarding my physical or mental condition and treatment rendered therefore, and, if necessary, to allow them or any physician appointed by them to examine any x-ray pictures taken of me or records regarding my physical or mental condition or treatment. In addition, I also authorize the release of HIV records, psychotherapy records, mental health records, and drug and alcohol treatment information under the same terms and conditions. (CIRCLE THOSE RECORDS, IF ANY, WHICH ARE NOT TO BE RELEASED.) A photocopy of this instrument may be used instead of the original. If not revoked earlier, this consent will remain in effect for 90 days from the date of signature.

____________________________ ____________________________ ________
(signature) (witness) (date)

____________________________ ____________________________
(date of birth) (social security number)