IntervalCare Medical Services, Inc
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CONSENT FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize IntervalCare Medical Services, Inc to obtain/release information including, if any, psychiatric or psychological information, infectious, or contagious disease information (including HIV/AIDS confidential information), and/or information about drug or alcohol abuse or treatment of same from the health record(s) of:

Patient Name:_____ Date of Birth:_____

Covering Period of Treatment - From:_____ To:_____

Information to be released: (check one)

- ☐ Complete Record
- ☐ Other, Specify:_____

Information NOT authorized for release:

_____

_____

Information is to be released to:

Name:_____

Address: _____

e-Fax: _____

Phone: _____

Purpose of Disclosure:_____

Patient/Legal Guardian
Signature:_____Date:_____