AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

Patient Name: _____ Date of Birth: _____

I hereby authorize Gabriel M. Pitman, D.O. to release photocopies of my medical records and/or health information.....

_____To the following named individual or organization: _____

_____

Or

_____ Into my own keeping.

I agree to pay $1.00 for the first page and 50 cents per each additional page for each copy or copies before such are released and will also pay the actual cost of postage if the record is to be mailed.

I further release _____Gabriel M. Pitman, D. O.____ from the responsibility for any deleterious effect the release of my clinical medical records may have upon myself or others both now and in the future. I personally accept all responsibility for my own distribution and interpretation of medical information contained therein and hold blameless Gabriel M. Pitman ,D.O. for conclusions or opinions drawn from said records without professional knowledge, assistance, or review.

State law, you must be advised that: **The information authorized for release may include records which may indicate the presence of a communicable or venereal diseases which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus also known as Acquired Immune Deficiency Syndrome (AIDS)**

I realize by the release and/or receipt of these records that I am accepting responsibility for the protection of my own right of medical record confidentiality.

_____ _____

Signature of patient Date

_____ _____

Signature of person authorized to sign if other than patient

Relationship to patient