David Fredenburg, MD, PA
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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Effective Dates: _____________ through _____________ (include the date this authorization will no longer be in effect)

Patient Name: ____ D.O.B. _________________

Patient Name: ____ D.O.B. _________________

Patient Name: ____ D.O.B. _________________

Street: ____

City/State/Zip: ____ Telephone: _____________________

Date records needed: _____________ I am permanently transferring care of the patient(s).

I hereby authorize **David Fredenburg, MD, PA** to **RELEASE** the records of my care **TO:**
(Records will only be released to the parent/guardian, or patient if 18 yo or older. Patients 18 yo or older will need to sign for their own records but may choose someone else to pick them up. To avoid losing charts they will not be sent to other clinicians' offices.)

Patient/Parent Name: ____
(circle one)

Address (Street): ____

Address (City/State/Zip): ____

I understand that the records will be used for: Continuing healthcare with a new clinician

Photocopies or originals of **all** records relating to patient care, including psychiatric/psychotherapy, mental health, drug/alcohol treatment, and HIV-related information, will be forwarded unless otherwise requested. I understand that release of some sensitive information in the record may have negative effects associated with it. **I request that records with the following information NOT be released:**

___ Alcohol / Substance Abuse

___ Psychiatric / Mental Illness

___ HIV / AIDS

___ Other (specify): ____

By signing this release, I authorize the indicated practice to release photocopies or originals of all medical records, charts, notes, and any other information regarding general physical or medical conditions, including confidential HIV-related information (unless otherwise noted above). I also understand that a limited portion of the records may be forwarded, if requested, via a facsimile or "FAX" machine.

Patient Signature: ____ Date: _______________

Parent Signature: ____ Date: _______________
(Required if patient is under 18 years of age)

Witness Signature: ____ Date: _______________

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