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AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL MEDICAL INFORMATION

I hereby authorize _____ to release photocopies, facsimile copies, or digital copies to Victor T. Wilson, M.D., P.C., of the following information from the health records of:

Patient Name(s) _____ Date of Birth(s) _____
_____ _____
_____ _____
_____ _____

Purpose:
_____ Transfer of care
_____ Copy of complete record
_____ Immunization record
_____ Other, specify:_____

The information you authorize for release may include information about communicable, non-communicable, or venereal diseases which ma include, but are not limited to diseases such as hepatitis, syphilis, gonorrhea, and the Immunodeficiency Virus also known as Acquired Immune Deficiency Syndrome (AIDS). By this acknowledgment, I release Victor T. Wilson, M.D., P.C., the facility, its employees and officers and the attending physician from any legal responsibility that may arise from the release authorization, and I waive all rights and privileges allowed by law relating to Disclosure of Confidential Information, Defamation, and Invasion of Rights of Privacy. I understand that this consent can be revoked at any time except for any disclosure already made in good faith, in reliance of this release.

IN SIGNING THIS CONSENT I RELEASE YOU FROM ANY LIABILITY THEREWITH

_____ _____
Signature of parent, patient, or legal guardian **Date**

_____
Printed name of parent, patient, or legal guardian

Phone number to other clinic: (_____)_____

Fax number to other clinic: (_____)_____