Loftus, Ryu, Bartol & Associates, MDs, PC

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Patient Authorization for Release of Medical Information

This form authorizes the disclosure of protected health information, which may include confidential HIV-related information.

Patient Name:_____ Date Of Birth:_____

Address:_____

Phone:_____

Send Medical Records **TO / FROM**:

Physician:_____ Phone/Fax:_____

Address:_____

Send Medical Records **TO / FROM:**

Loftus, Ryu, Bartol & Associates

Information to be disclosed:

_____

Date Range: From: _____ To: _____

*This authorization may include disclosure of HIV, alcohol and/or drug abuse and mental health treatment **ONLY** if you initial here. _____

Patient Signature:_____Date:_____