Medical Records Request

I, the undersigned, authorize _____ to release information from my medical records. This authorization includes release of information concerning treatment of psychiatric/ psychological conditions, drug and/or alcohol related conditions, and HIV and AIDS related conditions. Please release the following information:

Operative Report & path report of tubal sterilization of approximate date:

The purpose of this request is for continued medical care. I would appreciate having these records sent to the following address by way of fax to 502-589-3842 (Voice 502-584-7787).

Mailing Address: Richard M. Levin, M.D., PSC
225 Abraham Flexner Way #501
Louisville KY 40202

This authorization must be signed and dated, may be revoked at any time except to the extent action has been taken prior to revocation. Revocation must be made in writing. **This authorization will expire in six months from the date below**.

I hereby state that I have read and fully understand the above statements as they apply to me. I acknowledge that I understand treatment, payment, enrollment in any health plan, or eligibility for benefits are not conditioned on signing this authorization. I hereby authorize to the disclosure of the medical records to the purposed and extent stated above.

Medical Records Name:	
Current Name:	
Social Security Number:	
Date of Birth:	
Current Street Address:	
Current City, State, Zipcode:	
Phone Number:	
E-mail Address:	
Signature:	
Witness Signature:	
Date:	