SONI
FAMILY PRACTICE, PLLC

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Regarding:_____ **D.O.B.**_____
(Please print Patient's name) **Social Security #**_____

I give **Soni Family Practice, PLLC** the authorization to:

Obtain my medical records from:
Discuss my medical records with:
Release my medical records to:

Name: _____

Address: _____

Fax: _____ **Phone** _____

For the purpose of: _____

This release will include **GENERAL** medical information from my medical record as well **AS PSYCHIATRIC/PSYCHOLOGICAL** information, **ALCOHOL** and or **DRUG ABUSE** information, **HIV testing** and other information pertaining to these tests or to treatment in connection with these test results, and or testing for **SEXUALLY TRANSMITTED DISEASES (STDs)**

NOTE TO RECEIVING PARTY

This information is disclosed to you from records whose confidentiality are protected by law. Any re-disclosure is strictly prohibited without written permission of the patient/client/legal representative identified below.

I understand this consent is revocable by me, in writing, at any time except after the action has taken place. I also understand that this consent will expire either ninety days after the date of the signature or automatically when the records requested on this form have been turned over to the above requested provider.

Date:_____ **Signed**_____**(Patient)**

Signed_____**(Witness)**

Signed_____**(Parent/Guardian)**