<u>Authorization to Release Information to Family Members/Friends</u>

I, ____ authorize The Victoria Women's Clinic to release my records and any information requested to the following individuals:

Name(s):	**Relationship:**
____	_____________________________________
____	_____________________________________
____	_____________________________________

Health Information to be disclosed (Check all that apply):

___ My complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment and billing, for all conditions)

OR

___ My complete health record, as above, with the exception of the following information:

- _____ Mental Health Records
- _____ Communicable Disease (including HIV and Aids)
- _____ Alcohol/Drug Abuse
- _____ Other (please specify) ____
  ____

This authorization shall be effective until (Check One):

- ___ All past, present and future periods, OR
- ___ Date or Event: ____

  unless I revoke it (NOTE: You may revoke this authorization at any time by notifying your health care providers)

______________________________________ Name of Individual giving this Authorization (Print)

____ Signature of Individual giving this Authorization/ Date