Martin C. Aldrich, M.D.
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AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, request and authorize release of all medical information (including, but not limited to, information on psychiatric conditions, sickle cell anemia, alcohol and drug abuse, and HIV or communicable diseases) to the physician listed above.

This release is authorized for one year from the date of signing and all information will be regarded as confidential. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then be longer be protected by federal regulations.

Please forward to our office the following:

Complete medical, surgical and medication history

Office notes and examination findings

Laboratory reports

Radiology reports

EKG images and reports

Correspondence and consultation letters

Print Name:_____ Patient's Date of Birth:_____

Patient's Signature:_____ Today's Date:_____