Specialty Allocations
Future Solutions Now

General Release for Medical Information

Client: _____

Address: _____

DOB: _____ SSN: _____

You are hereby giving the authority to provide to Specialty Allocations, Inc. and/or any of his/her agents or representatives, medical records, correspondence, billing records, x-rays (including mammograms), diagnostic reports, laboratory slides, opinions, which they may request relative to the above named person's past, current or future physical condition, treatment, care and/or hospitalization and to allow them to procure or copy whatever medical records, x-rays, slides or other information you may have in your possession. This specifically includes any records pertaining to HIV/AIDS tests, psychiatrist/psychological testing or reports, and any records relating to substance and drug abuse as well as the obtaining of pictures or video if deemed necessary.

I, _____ , allow *Specialty Allocations, Inc.* to discuss my past, present and future medical needs with physicians, therapists, psychiatric counselors and other health care providers.

I understand that I can cancel this authorization at any time and that this consent will expire in one year from the date signed.

Please note: You are authorized to accept a copy of this release as though it were an original copy.

_____ _____
Client's Signature Date

_____ _____
Parent/Guardian Consent for Minor Date

_____
Relationship

_____ _____
Witness Date