Phone # 800-652-0592 Fax # 800-652-1625 Email info@buddoc.org

Medical Records Release Form

Patient Name: _____ Date of Birth: _____ /_____ /_____

Dates of treatment requested: ALL or From: _____To: _____

Release of Information:

From: _____ To: BudDocs and its physicians

Address: _____ Fax: 1-800-652-1625

_____ Email: info@buddoc.org

I_____, voluntarily and without coercion authorize the party above to obtain my health information indicated that is contained in my medical records. I understand and acknowledge that this may include treatment for physical and mental illness, alcohol/drug abuse and or HIV/AIDS test results or diagnosis.

This Release of Information will remain in effect until terminated by me in writing.

Notice of Privacy Practices: I acknowledge that I have reviewed the Notice of Privacy Practice available online at buddocs.org/terms.

Signature: _____ Printed name: _____

Date Signed: _____ Relationship: _____

If other than the patient's signature, a copy of legal paperwork verifying patient's personal representative must accompany the request. (i.e. Court appointment guardian, durable power of attorney for healthcare).