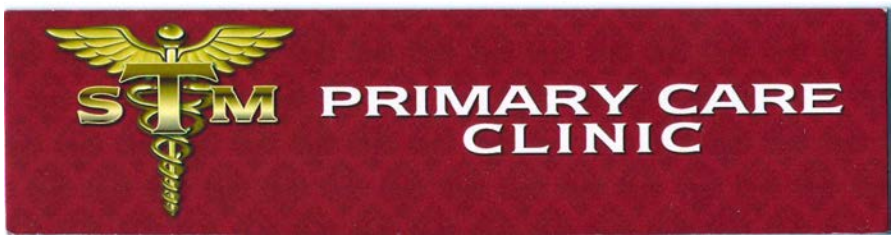

Authorization for Disclosure of Confidential Information

Patient Name:_____

DOB:_____ SSN:_____

I hereby authorize STM Primary Care Clinic and its agents to release the following medical Information:

Name of Facility _____

Address of Facility _____

[Check all That may be released]

Any of the following may include information relaed to HIV or AIDS, Sexually transmitted Diseases, Behavioral or Mental health, and drug or alcohol abuse. If you do not wish the release of this information, please specify:

_____Not to include any of the above _____ To include all of the above

_____Progress Notes _____Labs_____Radiology____EKG/Special Studies

_____Hospital/ER_____Psychiatric/Psychological_____Outside Medical Records_____Obstetric/GYN

This Authorization covers patient care from _____(date) to _____(date)

Purpose of Disclosure: _____Medical Care _____Attorney _____ Insurance _____Other

This authorization shall be valid for 90 Days from the dat of signature. I understand I have the right to revoke this authorization a any time. I understand that if I revoke this authorization, I must do so in writing. I understand that revocation will not apply to information which has alredy been released. I understand that this revocation does not apply to my Insurance company since they have the right, as defined in my policy, to obtain information necessary for my claims.

Patients Signature_____ Date: _____

Witness_____ Date: _____