Thomas Carmen MD and Associate
Village at Pine
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Wexford, Pa 15090
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Authorization For Release of Medical Information

Patient Name:_____ Date of Birth:_____

I authorize Thomas Carmen, MD and Associates to release my medical records to:

_____
Name of Physician/Hospital/Insurance Company/Other

_____
Street Address

_____
City, State, Zip Code

The following information is to be released:

_____ All medical records including any alleged or actual drug/alcohol abuse, sexually transmitted disease including any HIV/AIDS related information, mental health, psychiatric and/or psychotherapy treatment records. If any of this information is documented in my medical file, I agree to release it.

_____ All medical records with the exception of:
- _____ Drug and Alcohol Information
- _____ Sexually transmitted diseas including any HIV/AIDS information
- _____ Mental Health, psychiatric and/or psychotherapy information

Specify Date:
- _____ Entire Records
- _____ Last_____ years
- _____ Other:_____

Purpose:
- _____ Transfer of care to another provider
- _____ Treatment by another healthcare provider
- _____ Personal Use
- _____ Other:_____

Patient/Guardian
Signature:_____Date:_____