AUTHORIZATION TO RELEASE INFORMATION

I, _____, authorize Thomas Rohde M.D. to release the following medical information to:

_____ Any and all of my medical record (as of the date of this release).

_____ Any and all of my medical record except the following:

This release also specifically allows the release of the following information (this information will not be released unless the appropriate box is initialed):

_____Any record of treatment for Drug and/or Alcohol dependency or abuse

_____Any record of Mental Health Treatment

_____Any record of testing, care, treatment, reporting or research pertaining to infection with HIV or related diseases.

This information is being released for the following purpose(s) only:

_____

_____ and may not be used for any purpose or released to any other person(s) without my written consent.

This release is effective for six months from the date of execution, however, it may be revoked by me at any time by providing written notice to the above named party.

_____ _____

Patient/Legal Guardian of Patient Date

Witness