RELEASE FORM

_____ YES _____ NO I authorize HNWPC to release medical records to other requesting Physicians (including AIDS/HIV records)

_____YES _____ NO I authorize HNWPC to mail LAB results to me (including AIDS/HIV tests)

_____YES _____NO I authorize HNWPC to discuss medical issues, records, LAB results and diagnostic testing (including AIDS/HIV tests) to the name(s) listed below:

Please list the full name(s) and relationship to patient:

Name: _____

Emergency #: _____

Relationship: _____

Name: _____

Emergency #: _____

Relationship: _____

Print patient name: _____

Patient signature: _____

Date: _____