Authorization to Release Medical Records

AFRH Applicant information:

Full Name: _____

Other Name(s) Used: _____ Date of Birth: _____

Address:_____ City:_____ State:_____ Zip Code:_____

Phone: (_____)_____ Email (*Optional*): _____

Healthcare provider information:

Name: _____

Address:_____City:_____ State:_____ Zip Code:_____

Phone: (_____)_____ Fax: (_____)_____

I grant my permission to disclose information to the following entity:

Armed Forces Retirement Home	Armed Forces Retirement Home
3700 Capitol Street, NW, Admissions	1800 Beach Drive, Admissions
Washington, DC 20011	Gulfport, MS 39507

Specific information to be disclosed:

□ Medical Records covering the last twelve months

□ Patient history and office notes

☐ Billing records

☐ Insurance records

☐ Drug, Alcohol or Substance Abuse Records

☐ Mental Health Records

☐ HIV/AIDS-Related Information (Including HIV/AIDS Test Results)

Signature of Applicant: _____ Date: _____