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Medical Release Authorization

I hereby authorize the following people to receive any and all test results and I understand that information relevant to HIV testing and /or AIDS related diagnosis may be contained in this information.

1) _____ Relationship: _____

2) _____ Relationship: _____

3) _____ Relationship: _____

_____ _____
Signature of Patient Date

I do not authorize anyone to receive any tests results or medical history.

_____ _____
Signature of Patient Date

I will not hold Guillermo I. Rocha, MD, PA or staff responsible for release of information related to the above without my signature.

Under no circumstances can any changes be made verbally.

_____ _____
Signature of Patient Date

Patient Name: _____

Power of Attorney- Representative: _____

Med Record #: _____ Date of birth: _____ Note: _____