



AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION

INFORMATION MAY BE DISCLOSED BY:

Person/Facility: _____ **Phone #:** _____

Address: _____ **Fax #:** _____

INFORMATION MAY BE DISCLOSED TO:

Person/Facility: _____ **Phone #:** _____

Address: _____ **Fax #:** _____

INFORMATION TO BE DISCLOSED: (Initial Selection)

- | | |
|--|---|
| <input type="checkbox"/> General Medical Record(s) | <input type="checkbox"/> Immunizations |
| <input type="checkbox"/> History and Physical Results | <input type="checkbox"/> Prenatal Records |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Consultations |
| <input type="checkbox"/> Diagnostic Test Reports (Specify Type of test(s) _____) | |
| <input type="checkbox"/> Other: (specify) _____ | |

I specifically authorize release of information relating to: (initial selection)

HIV/AIDS for non-treatment purposes; Drug/Alcohol; Mental Health; WIC; Early Intervention

PURPOSE OF DISCLOSURE:

Continuity of Care Personal Use Other (specify) _____

EXPIRATION DATE: This authorization will expire (insert date or event) _____. I understand that if I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.

REDISCLASURE: I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

CONDITIONING: I understand that completing this authorization form is voluntary. I realize that treatment will not be denied if I refuse to sign this form.

REVOICATION: I understand that I have the right to revoke this authorization any time. If I revoke this authorization, I understand that I must do so in writing and that I must present my revocation to the medical record department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company, Medicaid and Medicare.

Client/Representative Signature

Date

Printed Name

Representative's Relationship to Client

Witness (optional)

Date

Client Name: _____

ID#: _____

DOB: _____