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)

_____ General Medical Record(s)
_____ History Physical and l Results
_____ Progress Notes
_____ Immunizations
_____ Prenatal Records s
_____ Consultation
_____ Diagnostic Test Reports (Specify Type of test(s) _____
_____ Other: (specify)_____

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

___ STD ___ HIV/AIDS ___ TB ___ Drug/Alcohol ___ Mental Health ___ WIC Eligibility ___ 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.

REDISCLOSURE: 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.

REVOCATION: 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: _____

Original: To File Copy: To Client Copy: To Accompany Disclosure

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