



**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 #: \_\_\_\_\_

Other method of communication: \_\_\_\_\_

**INFORMATION TO BE DISCLOSED:** (Initial Selection)

- General Medical Record(s), including STD and TB
- Immunizations
- Diagnostic Test Reports (Specify Type of test(s)) \_\_\_\_\_
- Other: (specify) \_\_\_\_\_
- Progress Notes
- Family Planning
- Prenatal Records
- History and Physical Results
- Consultations

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

- HIV test results for non-treatment purposes
- Psychiatric, Psychological or Psychotherapeutic notes
- Substance Abuse Service Provider Client Records
- Early Intervention
- WIC

**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.

**REVOCAATION:** 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:** \_\_\_\_\_