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AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Client Name:____________________________________ Date of Birth:____________

Release To____ From____

Name:_____________________________________ Contact #:___________________

Address:____

Release the following Information:

- ☐ Exchange information freely to coordinate care
- ☐ Health care information relating only to_____________________________________
- ☐ Other____

I agree the release may include information regarding testing, diagnosis and/or treatment for:

- Psychiatric disorder/mental health
- Drug and/or alcohol use
- Sexually transmitted diseases including HIV/AIDS

This authorization will end ________in 90 days or _______________________________

I understand that once the provider gives out the information, the provider has no control over it, the recipient may re-disclose it and privacy laws may no longer protect it.

I know that I may cancel this authorization in writing as allowed by law. This would *not* effect any actions already taken based upon my original request. I may cancel this authorization in one of three ways:

1. Sign, date and write “CANCEL” on the original form.
2. Write, sign and date a letter to the provider.
3. Sign and date a revocation form available from the provider.

Signature:____ Date_________________

Relationship to patient:____