CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

Information is requested from: _____

_____
(Street or PO Box)

_____
(City) (State) (Zip Code)

Records are to be sent to: _____

_____
(Street or PO Box)

_____
(City) (State) (Zip Code)

Patient's Name: _____
(Last Name) (First Name) (Middle) (Maiden Name)

Date of Birth: _____ _____
(Street or PO Box)

_____ _____
(Social Security #) (City) (State) (Zip Code)

FOR THE PURPOSE OF:

_____ Medical Care ___ Attorney: _____

_____ Insurance Benefits ___ Other: _____

_____ Disability Determination

Dates of Treatment: _____

Type of Treatment: _____

I hereby release the above-named providers from all liability that may arise from the release of information from my medical record. I understand that this information may include reference to conditions including psychological or psychiatric impairment, drug abuse and/or alcoholism, sexual assault, or tests for HIV, ARC, and/or AIDS.

I understand I have the right to revoke this authorization at any time by sending a written notification to the Privacy contact.

I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to inspect or copy the protected health information to be used or disclosed in this document. I can do this written notification to the Privacy Contact.

I understand that my treatment will not be conditioned on signing this authorization.

I understand that I have the right to refuse to sign this authorization.

_____
Signature of Patient or Personal Representative

_____
Print or Type Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority (attach necessary documentation)