WITSON LAW, P.C.

CLARENCE E. WITSON II
ATTORNEY AT LAW

AUTHORIZATION AND RELEASE TO DISCLOSE MEDICAL RECORDS
INCLUDING HIV & AIDS RELATED INFORMATION

Patient name: _____ **Date of Birth**: _____
SS#: _____ **Purpose for disclosure**: _____

I hereby authorize the use or disclosure of the above named individual's health information as described below.

The undersigned hereby authorizes _____ to make the disclosure of information for the following dates: _____

Company/Persons Authorized to Receive Information: **WITSON LAW, P.C., CLARENCE E. WITSON II ATTORNEY AT LAW – P.O. Box 93335, Phoenix, Arizona 85070.**

The specific information to be disclosed includes, but is not limited to the following: Any and all records, documents, billing, reports, clinical abstracts, histories and charts, of any kind and description, related to care or services provided to the patient named above.

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management 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 when the law provides my insurer with the right to contest a claim under my policy.

This authorization will expire upon completion of one year from today's date.

I understand that once the above information is disclosed, it may be re-disclosed by the recipient and that federal privacy laws or regulations may not protect the information.

I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

_____
Patient Date

If patient is unable to consent by reason of age or some other factor, state reasons:

_____ _____
Authorized Representative Date Relationship to Patient

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