Selah Place of Oregon County, Inc.

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I hereby authorize the ____ to release and
(Name of Medical Institution)

furnish the ____ any and all information
(Name of Law Enforcement Agency)

regarding the treatment of ______________________________________, DOB ____________,
(Name of Patient)

by your institution on or about ______________________, or thereafter. I acknowledge that a copy of
(Date of Treatment)

this release shall have the same force as the original. Further, I specifically authorize the release of information

pertaining to substance abuse (to include drugs/alcohol), mental health, behavioral health, and HIV/AIDS.

I further expressly waive any confidentiality requirement set forth by 42 CFR Part 2 or any other State or Federal

statute or regulation and hereby authorize the ____
(Name of Law Enforcement Agency)

to use all information received from you in any manner which it deems necessary for its prosecution in this matter.

Your full cooperation respectfully requested and authorized.

____
Signature

____
Printed Name

____
Address

____
Date