HEALTH RECORDS
RELEASE AUTHORIZATION

I, _____, authorize and release, in part or in whole,

, to disclose any information from the treatment records relating to my identity, diagnosis, prognosis, or

treatment to _____.

I understand that the specific type of information to be disclosed includes:

_____

_____

_____

_____

_____

_____

and that the purpose or need for the disclosure is to evaluate resident's health status for my admission to the facility indicated above.
I also understand that unless revoked in writing, this consent will remain in force for the period necessary to effectuate the purpose for which it is given.

_____ _____

Resident Signature Date

_____ _____

Responsible Party Resident Signature Date

_____ _____

Manager's Signature (or Authorized) Date