AUTHORIZATION TO RELEASE INFORMATION

Name:________________________________DOB:______________SSN:xxx-xx-________

Please **OBTAIN** information **FROM:**

____
Name of provider or clinic

____
Street Address

____
City, State, Zip Code

Phone:________________________________
Fax:__________________________________

Please **SEND** information **TO:**

____
Name of provider or clinic

____
Street Address

____
City, State, Zip Code

Phone:________________________________
Fax:__________________________________

I **AUTHORIZE** the following information to be disclosed: (***Please initial all that apply***)

______Entire Record
______Immunization Record
______Lab Tests
______TB Tests
______HIV/AIDS Record
______STD Record
______Psychiatric/Mental Health
______Alcohol/Substance Abuse
______Billing Record
______Other________
____
Date(s)____________

REASON for disclosure of health information: (Please initial)

______At my request
______Continuing Care
______Legal Purposes
______Job
______School
______Insurance Purposes
______Other________
____
____

EXPIRATION of this Authorization: (Please initial one)

______90 days after this signature date
______On this date________________________________

ADDITIONAL PATIENT INFORMATION:

* I understand that I have the right to withdraw this authorization.
* I understand that I do not have to sign this authorization to get treatment.
* I understand that signing this authorization does not cancel any rights I have under the other state or federal laws.

____ Date:__________________
Client Signature (Parent or Legal Representative, if applicable)

*I wish to withdraw this authorization:________________________________ Date:__________________

Witness Signature:________________________________ Date:__________________