AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Client Name _____ **Date of Birth** _____

Client Medical Record # _____ **Client SS #** (Optional) _____

I _____ hereby authorize _____
(Client or Personal Representative) *(Name of Provider/Plan)*

to disclose specific health information from the records of the above named client to: (Recipient Name/Address/Phone/Fax)

_____

_____

_____

for the specific purpose(s):

_____

_____

Specific information to be disclosed:

_____

_____

_____

I understand that this authorization will expire on the following date, event or condition:

_____

_____

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for financial transactions, wherein the authorizations is valid indefinitely. I also understand that I may revoke this authorization at any time and that I will be asked to sign the Revocation Section on the back of this form. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I understand that any information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state and federal law.

I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing this disclosure will include that information. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given.

I further understand that I may request a copy of this signed authorization.

_____ _____ _____
(Signature of Client) *(Date)* *(Witness - If Required)*

_____ _____ _____
(Signature of Personal Representative) *(Date)* *(Personal Representative Relationship/Authority)*

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NOTE: This Authorization was revoked on _____ _____
(Date) (Signature of Staff)