



Authorization for Release of Information

PLEASE PRINT!

I, _____, hereby authorize the release of
Last Name First Name MI

medical information as documented below:

Date of Birth ____/____/____ Social Security Number ____-____-____

Former Name _____

Date(s) of Treatment _____

OBTAIN FROM:

Name of Agency

Address (No. & Street Name)

City, State, Zip Code

SEND TO:

Name of Agency

Person Requesting Information

Address (No. & Street Name)

City/State/Zip Code

Phone No./Fax No.

Please Note: The information checked below is being requested for the following purposes:

NATURE OF INFORMATION TO BE RELEASED (Check all that apply)

- Intake Assessment(s) Substance Abuse History Consultation Reports
Psychiatric Evaluation(s) Physicians' Orders Discharge Summary
Psychological Evaluation(s) History & Physical Emergency Report
Court Ordered Evaluation(s) Progress Notes Other
Treatment Plans IEPs Connors' Scale

I understand that my medical records is protected under the Federal Regulations 42CFR, Part II governing the Confidentiality of Alcohol/Substance Abuse records, Psychiatric, HIV/AIDs, and cannot be disclosed without my written consent unless s specified in the regulations. This authorization is valid until _____ or no longer than one (1) year from the date signed. I further understand that I may revoke this consent at any time except to extent that action has already been taken upon it.

PROHIBITION OF RE-DISCLOSURE: Federal regulations regarding the confidentiality of medical records prohibits the re-disclosure of this information without the specific written consent of the patient or legal representative.

Signature of Patient/Guardian/Legal Representative

Date

(Spouse, if none, child, if none, parent, if none, sibling, if none, aunt or uncle, etc)

Relationship to Patient _____

Witness Signature _____