Authorization To Disclose Confidential Information

INFORMATION MAY BE DISCLOSED BY:

Person/Facility: _____

Phone #: _____

Address:

_____

INFORMATION MAY BE DISCLOSED TO:

Person/Facility: _____

Phone #: _____

METHOD OF DISCLOSURE:

_____ Pick up at Clinic/Facility

_____ Address: _____

_____ Fax #: _____

_____ Email Address: (please note that emailing may not be a secured method of communication) _____

INFORMATION TO BE DISCLOSED: (Initial Selection)

☐ General Medical Record(s), including STD and TB

☐ Progress Notes

☐ History and Physical Results

☐ Immunizations

☐ Family Planning

☐ Prenatal Records

☐ Consultations

☐ Diagnostic Test Reports (Specify Type of test(s)

☐ Other: (specify) _____

I specifically authorize release of information relating to: (initial selection)

☐ HIV test results for non-treatment purposes

☐ Substance Abuse Service Provider Client Records

☐ Psychiatric, Psychological or Psychotherapeutic notes

☐ Early Intervention

☐ WIC

PURPOSE OF DISCLOSURE:

☐ Continuity of Care

☐ Personal Use

☐ Other (specify) _____

EXPIRATION DATE: This authorization will expire [Insert date or event] _____. I understand that if I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.

REDISCLOSURE: I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

CONDITIONING: I understand that completing this authorization form is voluntary. I realize that treatment will not be denied if I refuse to sign this form.

REVOCATION: I understand that I have the right to revoke this authorization any time. If I revoke this authorization, I understand that I must do so in writing and that I must present my revocation to the medical record department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company, Medicaid and Medicare.

_____

Client/Legal Representative Signature

_____

Date

_____

Printed Name

_____

Legal Representative’s Relationship to Client

_____

Witness (optional)

_____

Date

If you are a legal representative of the person whose information you are requesting, you must provide documentation proving your legal authority to the request this information (for example, power of attorney, healthcare surrogate form, order, appointment of a guardianship, order appointing personal representative, letters of administration).

Client Name: _____

ID#: _____

DOB: _____

Original: To File **Copy:** To **Client Copy:** To Accompany Disclosure