

AUTHORIZATION TO RELEASE CONFIDENTIAL HEALTH INFORMATION

I hereby authorize release of my confidential health information as described below. I understand this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations.

Client name: _____

Provider or Facility providing the information:

Persons/organizations receiving the information:
(include mailing address, phone, and fax number -
otherwise, we will be unable to facilitate your request)

Description of specific information to be disclosed (including dates of service):

Does this include authorization to release drug or alcohol abuse treatment records? Yes ___ No ___ (please initial)
Does this include authorization to release psychotherapy notes? Yes ___ No ___ (please initial)

The release of information is being made:
 At the request of the individual
 At the request of another, explain the purpose of the request. _____

This authorization will expire on ____/____/____ (DD/MM/YY)

Carefully read the following statements before signing this authorization:

- 1. I may revoke this authorization at any time in writing, except as to information released before receipt of the revocation.
- 2. I understand that my health care will not be denied if I refuse to sign this authorization.
- 3. Information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer subject to privacy protections.
- 4. I am entitled to a copy of this authorization.

Signature of Client or Client's representative

Date

Printed name of Client's representative:

What is the representative's authority to act on behalf of the Client?

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION