AUTHORIZATION FOR RELEASE
OF CONFIDENTIAL INFORMATION

Regarding

____
(Print Patient's Name)

NOTE TO RECEIVING PARTY: This information is disclosed to you from records whose confidentiality is protected by law. Any redisclosure is strictly prohibited without the written permission of the patient/client/legal representative identified below.

I authorize ____Phone (   )________________
(Name of facility/person holding information)

____
(Address)

____
(City/State/Zip Code)

to release written general medical information from my medical record as well as psychiatric/ psychological information, alcohol and/or drug abuse information, Human Immunodeficiency Virus (HIV) tests and other information pertaining to these tests or to treatment in connection with these test results to:

____
(Name of facility/person to receive information)

____
(Address)

____
(City/State/Zip Code)

for the purpose of ____

____ _____________________________
Patient's/Legal Representative's Signature / Date Date of Birth

____
Signature of Witness / Date

____
Legal Representative's Relationship to Patient

__ __
USE THIS SPACE ONLY FOR OFFICE USE

__________________________ ____
Date Mailed Signature of Staff Representative