AUTHORIZATION TO RELEASE INFORMATION

Name:________________________________ DOB:____________ SSN:xxx-xx-________

Please **OBTAIN** information **FROM:**	Please **SEND** information **TO:**
Name of provider or clinic	Name of provider or clinic
Street Address	Street Address
City, State, Zip Code	City, State, Zip Code
Phone:________________________	Phone:________________________
Fax:__________________________	Fax:__________________________

I **AUTHORIZE** the following information to be disclosed: (***Please initial all that apply***)

______Entire Record	______HIV/AIDS Record	______Billing Record
______Immunization Record	______STD Record	______Other________
______Lab Tests	______Psychiatric/Mental Health	________________
______TB Tests	______Alcohol/Substance Abuse	Date(s)__________

REASON for disclosure of health information: (Please initial)

______At my request	______Job	______Other________
______Continuing Care	______School	________________
______Legal Purposes	______Insurance Purposes	________________

EXPIRATION of this Authorization: (Please initial one)

______90 days after this signature date ______On this date________________________________

ADDITIONAL PATIENT INFORMATION:

* I understand that I have the right to withdraw this authorization.
* I understand that I do not have to sign this authorization to get treatment.
* I understand that signing this authorization does not cancel any rights I have under the other state or federal laws.

____ Date:______________

Client Signature (Parent or Legal Representative, if applicable)

*I wish to withdraw this authorization:______________________________ Date:______________

Witness Signature:______________________________ Date:______________