# 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:**

_____ **General Medical Record(s), including STD and TB** _____ **Progress Notes** _____ **Family Planning**

_____ **Prenatal Records** _____ **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**

**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 services 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 Agency. 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

# AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION

| | |
|---|---|
| _____ | _____ |
| 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 request this information (for example, power of attorney, healthcare surrogate form, order, appointment of guardianship, order appointing personal representative, letters of administration).

**Client Name:** _____

**ID #:**_____

**DOB:** _____

**Case Manager:** _____