RELEASE OF INFORMATION

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Client's name: ____
First Name Middle Name Last Name

Date of Birth: _____/_____/_____

Date authorization initiated: _____/_____/_____

Person(s) Authorized to Make the Disclosure:

____

Person(s) Authorized to Receive the Disclosure:

____
____
____

Specific information to be released:

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____
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____

This Authorization will remain until the client specifically requests otherwise.

Authorization and Signature: I authorize the release of my confidential protected health information, as described in the above directions. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

Signature of the Patient:
____
Date

Signature of Parent/Guardian:
____
Date