Release of Information

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Client name: _____
First Middle Last

Date of Birth: _____

Date authorization initiated: _____

Person authorized to <u>make</u> the disclosure:
_____
_____
_____

Person(s) authorized to <u>receive</u> the disclosure:
_____
_____
_____
_____
_____

Specific information to be released:
_____
_____
_____
_____
_____
_____

(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.

_____
Name Date