

## CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

Information is requested from: \_\_\_\_\_  
\_\_\_\_\_  
(Street or PO Box)  
\_\_\_\_\_  
(City) (State) (Zip Code)

Records are to be sent to: \_\_\_\_\_  
\_\_\_\_\_  
(Street or PO Box)  
\_\_\_\_\_  
(City) (State) (Zip Code)

Patient's Name \_\_\_\_\_  
(Last Name) (First Name) (Middle) (Maiden Name)

Date of Birth: \_\_\_\_\_  
\_\_\_\_\_  
(Street or PO Box)  
\_\_\_\_\_  
(Social Security #) (City) (State) (Zip Code)

**FOR THE PURPOSE OF:**

- \_\_\_\_\_ Medical Care
- \_\_\_\_\_ Insurance Benefits
- \_\_\_\_\_ Disability Determination
- \_\_\_\_\_ Attorney: \_\_\_\_\_
- \_\_\_\_\_ Other: \_\_\_\_\_

Dates of Treatment: \_\_\_\_\_

Type of Treatment: \_\_\_\_\_

I hereby release the above-named providers from all legal liability that may arise from the release of information from my medical record. I understand that this information may include reference to conditions including psychological or psychiatric impairment, drug abuse and/or alcoholism, sexual assault, or tests for HIV, ARC, and/or AIDS.

I understand that I have the right to revoke this authorization at any time by sending a written notification to the Privacy Contact.

I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to inspect or copy the protected health information to be used or disclosed as described in this document. I can do this written notification to the Privacy Contact.

I understand that my treatment will not be conditioned on signing this authorization.

I understand that I have the right to refuse to sign this authorization.

\_\_\_\_\_  
Signature of Patient or Personal Representative Date

\_\_\_\_\_  
Print or Type Name of Patient or Personal Representative

\_\_\_\_\_  
Description of Personal Representative's Authority (attach necessary documentation).