

# AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

I hereby authorize \_\_\_\_\_ or its agent(s) to disclose my health information as described in this authorization:

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

SSN: \_\_\_\_\_ Previous Name: \_\_\_\_\_

Please release health care information to/from:

Name and Organization: \_\_\_\_\_

Address: \_\_\_\_\_

City/State: \_\_\_\_\_ Zip \_\_\_\_\_

Release the following information:

Health care information relating to the following treatment or condition: \_\_\_\_\_

Health care information for the following dates: \_\_\_\_\_

All health care information: \_\_\_\_\_

All health care information *excluding* the following: \_\_\_\_\_

All mental health information, including assessment, diagnosis and treatment: \_\_\_\_\_

Substance Abuse Evaluation done on the following date: \_\_\_\_\_

Discharge Plan done on the following date: \_\_\_\_\_

Results of drug screen done on the following date: \_\_\_\_\_

Dates of attendance for individual or group therapy as follows: \_\_\_\_\_

Other \_\_\_\_\_

Expiration of Authorization: This authorization will expire (*choose and complete one*):

In 90 days; or

When the following occurs: \_\_\_\_\_

Right to Revoke: I may cancel this authorization in writing as allowed by law. This would not affect any actions already taken based upon my original request. There are three ways to cancel this authorization:

- 1) Sign and date a revocation form.
- 2) Write, sign and date a letter to the above agent at the following address:

\_\_\_\_\_,

requesting that the authorization be cancelled; or

- 3) Sign, date and write "CANCEL" on this original form.

Potential for Redislosure: Once this information is released, the person/organization releasing it has no control over it. The recipient might re-disclose it. Privacy laws may no longer protect it.

Right to Copy: I understand that I am entitled to receive a copy of this authorization.

