

Authorization for Disclosure

Client Information

Client Name _____ Date of Birth _____ Telephone _____
(First, MI, Last)

Mailing Address _____ State _____ Zip Code _____

Requester Information

(To be completed if authorization is being made by someone other than the subject of the information. Please provide documentation of your authority).

Requester Name (if different than client) _____ Telephone _____

Mailing Address _____ State _____ Zip Code _____

Authorization Details

I authorize the following individual, organization or business _____

to disclose my confidential information to: _____

for the purpose of : _____

Please describe in detail the information to be disclosed. _____

This authorization will expire in 6 months unless another date or event is specified here _____

I understand that, at my request, a copy of the completed and signed authorization form will be made available to me. I understand that I may revoke this authorization in writing, at any time, except to the extent that action has been taken in reliance upon this authorization. I may submit my written statement of revocation

to: _____ I understand that the person or entity who receives my confidential information may not be required to prevent unauthorized use or disclosure.

I understand that this authorization, unless expressly limited by me in writing, will extend to all aspects of my treatment including testing and/or treatment for sexually transmitted diseases, AIDS, or HIV infection, alcohol and/or drug abuse and mental health conditions.

I understand that my signature on this form is not required for treatment, payment, enrollment, or eligibility for benefits, and that a copy of this authorization shall be as valid as the original.

Your Signature _____ Date _____

Your signature must be notarized if we are unable to verify your identity and you submit this request by mail.