Release Authorization to Disclose Confidential Information

Patient Name:_____ Former Name:_____
Last First MI
Address:_____
Street City State Zip

Phone: ( )_____ DOB_____

I, _____ authorize_____
(Patient/Legally Authorized Representative) (Name of Disclosing Party/Institution)

_____Phone: ( ) _____
(Address)
_____ Fax #: ( ) _____
(City, State, Zip)

TO DISCLOSE THE FOLLOWING HEALTH INFORMATION (Please describe the information to be disclosed):_____
_____
_____

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information:

_____HIV/AIDS Information

_____Mental Health Information

_____Drug/alcohol diagnosis, treatment or referral information

TO: (receiving party) _____
(Name of Person / Organizational Affiliation)
_____Phone: ( )_____
(Address)
_____ Fax #: ( )_____
(City, State, Zip)