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AUTHORIZATION FOR EXCHANGE OF INFORMATION

Client name: _____ Date of Birth: _____

Information about you cannot be exchanged without your consent. Your signature on this release authorizes your provider to obtain or release medical records or information regarding your care. For the purposes hereof, “Medical Records” include all confidential HIV-related information, confidential communicable disease-related information, confidential alcohol or drug-abuse related information, and confidential psychological, behavioral health, medical, and educational data.

This disclosure is for the purpose of diagnosis, treatment planning, follow-up, subpoena for records, coordination of care, employment, and/or any reason listed below:

_____

The following limitations/exceptions to the disclosure of this information apply:

_____

□ Please release information to:

□ Please request information from:

_____
Name

_____
Mailing Address

_____
City, State, Zip

_____
Phone #/Fax #

□ Please release information to:

□ Please request information from

_____
Name

_____
Mailing Address

_____
City, State, Zip

_____
Phone #/Fax #

I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. This consent will expire automatically one year from the date on which it is signed. Any disclosure of medical record information by the recipients is not authorized except when implicit in the purposes of this disclosure.

_____
Signature of Client or Authorized Guardian

_____
Date:

_____
Signature of Client or Authorized Guardian

_____
Date: