

**AUTHORIZATION FOR DISCLOSURE OF HEALTHCARE INFORMATION**

Client Name: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS#: \*\*\*-\*\*-\_\_\_\_\_

Previous Name(s): \_\_\_\_\_ Address: \_\_\_\_\_

I authorize \_\_\_\_\_ to release/exchange the following information. I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment.

**INITIAL BELOW ANY INFORMATION NOT TO BE RELEASED FROM THE RECORDS.**

\_\_\_\_ Psychological / Psychiatric Records      \_\_\_\_\_ Evaluation and Treatment  
\_\_\_\_ Chemical dependency/substance abuse Treatment      \_\_\_\_\_ HIV/AIDS and/or sexually transmitted diseases  
\_\_\_\_ Psychological testing  
\_\_\_\_ Other: \_\_\_\_\_

*Note: We have a dedicated fax line for privacy purposes. However, it is possible a provider could dial a wrong number in attempting to fax the requested documents. In such an event, most fax cover sheets indicate that the information contained therein is confidential and, if the document was received in error, the documents should be destroyed and the sender notified.*

**TO/WITH:**

\_\_\_\_ Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**TO/WITH:**

\_\_\_\_ Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**TO/WITH:**

\_\_\_\_ Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

\_\_\_\_ Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

*I understand that this release expires one year from the signed date, or that I may revoke this Authorization at any time except to the extent that action has been taken.*

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

**Parent/Guardian signature** is required for all children under age 13. For children age 13 and over, we encourage the parent/guardian to sign, but it is not required. *I understand that information being requested for the above minor child may include information regarding myself, the parent/legal guardian, relevant to my child's condition and treatment. I consent to the disclosure of such information.*