AUTHORIZATION FOR RELEASE OF INFORMATION

Patient's Name: _______________________________ Birth Date: _______/_______/________

I, the undersigned, hereby authorize and request ____

(Agency or Health Provider Name & Address)

to release to: ____

(Name) (Address) (City) (State/Zip)

the following information:

[ ] General Medical Information [ ] Lab & X-Ray Data

[ ] Reports from Other Facilities or Physicians [ ] Mental Health Treatment

[ ] Drug or Alcohol Abuse [ ] HIV Related Information

[ ] Other (specify if only partial info/specific dates are needed) ___________________________

Such information disclosed or delivered may include complete case history as shown by the records, and any other information in your possession relating to (my/his/her) treatment or condition. I understand I have the right to inspect the information to be disclosed.

X____/______/______

(Signature) (Date)

____

(Address) (City) (State/Zip)

____

(Relationship, if not patient) (Witness)

SPECIFIC AUTHORIZATION FOR RELEASE OF MENTAL HEALTH INFORMATION AND/OR DRUG ABUSE INFORMATION AND/OR HIV INFORMATION

I acknowledge that data to be released MAY INCLUDE material that is protected by Federal Law and that is applicable to EITHER Mental Health Information or Drug/Alcohol Abuse or HIV information. My signature authorizes release of all information (as specified above).

X____/______/______

(Signature) (Date)

In order for the above information to be released, you must also sign the

SPECIFIC AUTHORIZATION RELEASE.