AUTHORIZATION FOR RELEASE OF INFORMATION

Person: _____

DOB: _____

SSN: _____

I, _____,
(Name and Address of Person/Organization Authorizing Release of Information)

hereby authorize _____ to **RELEASE** and/or **RECEIVE** *(circle)*

information (i.e., verbal, written, or otherwise) to/from _____

relevant to the care, treatment, and/or services rendered to _____.
(Name of Service Recipient)

By initialing and signing next to the following, I am specifically authorizing the release of medical/healthcare information related to the testing, assessment, diagnosis, and treatment of:

____ HIV/AIDS _____

____ Sexually Transmitted Diseases _____

____ Alcohol/Drugs _____

____ Genetic Testing _____

____ Reproductive Care (minors only) _____

____ Mental Health _____

____ Other (specify) _____

_____

The authorization shall be valid until _____ or until it is revoked by me in writing, at which time it will expire and no further release of records shall be made under its terms. Furthermore, I understand that I can revoke this authorization at any time, except with respect to actions already taken by the above noted parties in reliance upon it. I also understand that I have the right to examine and copy the information to be disclosed and to submit clarifying or correcting statements and other documentation of reasonable length for inclusion with the confidential information. I certify that this form has been explained to me, or I have read and understood the form and its contents. A copy and/or fax of this authorization, which contains my signature, shall be considered as effective and valid as the original and shall be honored by those to whom it is sent.

_____ _____
Signature of Service Recipient Date

_____ _____
Signature of Legal Guardian (if not service recipient) Date

_____ _____
Signature of Witness Date