Authorization to Release Health Care Information

Client Name: ____ Date of Birth: ___/____/_______

Other name(s) used by client: ____

Parent/Guardian Name: ____

Please release health care information to:

Name and Organization: ____

Address: ____

City, State: ____ Zip Code: _________________

Release the following Information:

☐ Health care information relating to the following treatment or condition:

____

☐ Health care information for the date(s) below:

____

☐ All health care information:____

☐ Other: ____

This authorization ends in 90 days or on ____/_____/______.

I may cancel this authorization in writing as allowed by law. This would not affect any actions already taken based upon my original request for release of health care information.

**Once health care information is given out by Brenda Newell, LICSW, she has no control over it. The recipient might re-disclose it. Privacy laws may no longer protect it.

I also agree to the release of health care information regarding testing, diagnosis, and /or treatment for:

☐ HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use.

____ __________________ ___________

Client or legally authorized individual signature | Date | Time

____

Relationship to client of authorized individual if signed on behalf of client