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Authorization to Release/Receive Information

Client Name: _____DOB: _____

SS# _____

I hereby authorize _____to Release/Obtain to/from:

Name/Agency: _____

Address: _____

Phone: _____
The Purpose of the Disclosure is (are): _____

I hereby authorize the release of information. I understand that the information to be released may be confidential and protected from disclosure. I understand that I have the right to cancel my permission to release information at any time before it is released.

_____
Signature Date

_____
Printed Name

_____
Witness (sign and print name) Date

Other important information:
*I understand the Provider cannot guarantee that the Recipient will not disclose my health information to a third party.
*I understand that the Authorization is not required to share information permissible under federal law and regulations or to comply with law regarding mandatory reporting of suspected abuse, neglect or regulations or exploitation, or assessment that there is a danger of serious harm to self or others.
*I understand that I may refuse to sign this Authorization and that my refusal to sign will not have any effect on any action taken by the Provider in reliance on the Authorization before written notice of revocation by the Provider.
*I understand that I may revoke this Authorization in writing at any time, except that the revocation will not have any effect on any action taken by the Provider in reliance on the Authorization before the Provider receives written notice of revocation.