

Authorization for Release of Health Screening Information

Client Name (Last, First): _____ Birthdate: _____

Medical Record # _____ Soc.Sec. # _____ Client Phone # _____

Client Address: _____ City, State, Zip _____

I hereby authorize (NAME OF ORGANIZATION) to release health information to:

Name of person/facility to receive info: _____

Specify name/title of person if known: _____

Address, City, State, Zip: _____

Phone number: _____ Fax number: _____

Information to be released for dates beginning _____ and ending _____:

The purpose of this release is:

- Continuity of care or referral
- Request of the client/client representative
- Other (specify): _____

EXPIRATION OF AUTHORIZATION: Unless otherwise revoked, this authorization expires _____ (date or event). If no date is indicated, this authorization will expire 12 months after the date of signing of this form.

NOTICE: (NAME OF ORGANIZATION) as well as many other organizations and individuals such as physicians, hospitals, and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

MY RIGHTS:

- I understand this authorization is voluntary. Treatment, payment enrollment or eligibility for benefits may not be conditioned on signing this authorization except if the authorization is for: 1) conducting research-related treatment, 2) obtaining information in connection with eligibility or enrollment in a health plan for 3) determining an entity's obligation to pay a claim, or creating health information to provide to a third party. Under no circumstances, however, am I required to authorize the release of mental health records.
- I may revoke this authorization at any time, provided that I do so in writing and submit it to **(NAME OF ORGANIZATION AND ADDRESS)**. The revocation will take effect when **(NAME OF ORGANIZATION)** receives it, except to the extent that **(NAME OF ORGANIZATION)** or others have already relied on it.
- I am entitled to receive a copy of this Authorization.

PERSONAL USE: I understand I will be charged a per page fee for copies produced for my personal use. _____ (Client's initials)

Client/Legal Representative PRINTED name

Client/Legal Representative signature

Date

Time

Relationship to client if not client

Witness