Authorization To Release/Request Confidential Information

I, _____; _____; _____; (_____);
(Patient's LAST Name) (FIRST Name) (MIDDLE Name) (MAIDEN Name)

_____ hereby authorize _____ to request/release the
(Date of Birth) (Clinician Name)

following information concerning me/my child from/to:

_____
(Name of Person/Hospital/Agency)

_____
(Street Address)

_____
(City, State, Zip Code)

Information from the period listed below:

_____ to _____
(Month/Day/Year) (Month/Day/Year)

Phone: _____ Fax: _____

Information to be Released:

- ☐ Medication Information
- ☐ Psychological Testing
- ☐ Treatment Planning
- ☐ Progress Notes
- ☐ Entire Record
- ☐ Diagnosis
- ☐ Assessment Information
  - ☐ Lab Results
  - ☐ Discharge Summary
- ☐ Treatment Summary
  - ☐ Verbal Communication Only
  - ☐ Other: _____
- ☐ Attendance Only

The purpose for the release is: _____

I, the undersigned, understand that I may revoke this consent at any time by giving notice to my clinician. However, I also understand that any information released prior to my revoking this authorization shall not be a breach of my right to confidentiality. **This consent shall expire 90 days from date of signature unless another date is specified.**

To the party receiving this information: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42) CFR Part 2 prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.
FOR PATIENT RECORDS APPLICABLE UNDER FEDERAL LAW 42 CFR PART 2.

_____ _____
(Signature of Patient or Authorized Representative) (Date of Signature)

_____ _____
(Signature of Parent/Guardian) (Name of Child/Minor)

_____ _____
(Signature of Witness) (Witness' Relationship to Patient)

This release shall expire in **90** days or on _____.
(Month/Day/Year)