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### Authorization to Release Health Care Information

Client name: \_\_\_\_\_ Date of birth: \_\_\_\_\_  
SSN: \_\_\_\_\_ Previous name: \_\_\_\_\_

#### Please release health care information to:

Name and Organization: \_\_\_\_\_  
Address: \_\_\_\_\_  
City and 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  
\_\_\_\_\_ when the following occurs (but not longer than 90 days)

\_\_\_\_\_

I may cancel this authorization in writing as allowed by law. This would not affect any actions already taken based upon my original request. There are three ways to cancel this authorization:

- 1) Sign and date a revocation form. This form is available from (physician or clinic); or
- 2) Write, sign, and date a letter to the (physician or clinic) to cancel the authorization; or
- 3) Sign, date and write "CANCEL" on this original form

Once the (physician or clinic) gives out the information, the (physician or clinic) 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

\_\_\_\_\_  
Patient or legally authorized individual signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to patient if signed on behalf of the patient by parent, legal guardian, personal representative, etc.