

AUTHORIZATION FOR EXCHANGE OF INFORMATION

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Patient name: _____ Date of Birth: _____

Information about you cannot be exchanged without your consent. Your signature on this release authorizes your provider to obtain or release medical records or information regarding your care. For the purposes hereof, "Medical Records" include all confidential HIV-related information, confidential communicable disease-related information, confidential alcohol or drug-abuse related information, and confidential psychological, behavioral health, medical, and educational data.

This disclosure is for the purpose of diagnosis, treatment planning, follow-up, subpoena for records, coordination of care, employment, and/or any reason listed below:

The following limitations/exceptions to the disclosure of this information apply:

Please release information to and/ or request information from:

_____	_____ Primary Care/ Medical provider	
Name		
_____	_____ Therapist/ Psychologist	
Mailing Address		
_____	_____ Other: _____	
City	State	Zip Code

Phone Number	Fax Number	

I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. This consent will expire automatically one year from the date on which it is signed. Any disclosure of medical record information by the recipients is not authorized except when implicit in the purposes of this disclosure.

Signature of client or authorized person

Date

Witness

Date