



AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION
Including Medical and Mental Health Records

Patient's Name: _____ Date of Birth: _____

Previous Name(s): _____ Social Security #: _____

I request and authorize _____ to

release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax : _____

Federal Regulation, 42 CFR Part 2, requires that a description of the amount, the kind of information that is to be disclosed and the purpose for this disclosure.

This request and authorization apply to: ☐ All records available ☐ All correspondence

Or the specific records indicated here:

- | | |
|---|--|
| ☐ Psychiatric Evaluation | ☐ Psychological Testing |
| ☐ Diagnosis | ☐ School Evaluation |
| ☐ Summary of Treatment | ☐ History |
| ☐ Medications | ☐ Legal issues/concerns |
| ☐ Psychological Assessment | ☐ Performance |
| ☐ Other (specify) _____ | |

and is to be released for the purpose of: ☐ Continuity of care ☐ Other: (specify) _____

By checking the boxes below, I specifically authorize the voluntary release of the following types of medical records, if such records exist.

- | | |
|--|--|
| ☐ Yes ☐ No | I authorize the release of my HIV/AIDS records, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone. |
| ☐ Yes ☐ No | I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above. |



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This consent to release is valid for **one year**, or until otherwise specified, and thereafter is invalid.
Specify date, event, or condition on which permission will expire:

I understand that at any time between the time of signing and the expiration date listed above I have the right to revoke this consent at any time to the extent that information has already been released based on this authorization.

Patient Signature: _____

Date Signed: _____

Relationship to Patient: _____