

Authorization For Release of Information Form

Client's Name: _____ Date of Birth: _____

(first name last name)

(mm/dd/yy)

Self OR Printed name of client's representative: _____

Relationship to client: _____

I hereby authorize Child & Family Development to use or disclose individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

INFORMATION AUTHORIZED: (mark or specify) Designated Record Set

Other: _____

DATES AUTHORIZED: (mark or specify) All Other: _____

PURPOSE OF REQUEST: (mark all that apply) Exchange all medical Information

Release Information Only Request Information Only Verbal or Email Communication Only

PERSONS/ ORGANIZATIONS: (complete all fields)

NAME	ADDRESS	PHONE/ FAX #	RELATIONSHIP

ADDITIONAL INFORMATION ABOUT AUTHORIZATIONS

• I understand that this authorization will expire upon the minor's age of majority UNLESS an alternate date of my choice is specified here: _____ (MM/DD/YY) If client is over 18 and no date is listed, authorization will expire 1 year from date signed.

• I understand that I may revoke this authorization at any time by notifying the providing organization and completing a Revocation of Authorization Form. I understand that revocation will not apply to information that has already been released in response to this authorization.

• I understand that authorizing the disclosure of this private health information is voluntary and I may refuse to sign this authorization.

• I understand that I may request to inspect or obtain a copy of the information to be used or disclosed.

X _____

Signature of client or client's representative

Date