

## AUTHORIZATION TO RELEASE PATIENT INFORMATION

I \_\_\_\_\_ hereby authorize  
(Print/Type Patient Name)  
\_\_\_\_\_ its director or designee  
(Name of Health Care Provider)

or Medical Record Department to release information contained in my medical record, including information about Human Immunodeficiency virus (HIV), Acquired Immunodeficiency Syndrome (AIDS), and AIDS Related Complex (ARC); and including substance abuse treatment records protected under the regulations in Code 42 of Federal Regulations, Part 2, if any; psychological and social services records, including communications made by me to a social worker or psychologist, if any; to the individuals or organizations listed below, only under the conditions listed below:

Birthdate of Patient \_\_\_\_\_ Social Security Number \_\_\_\_\_

1. Name of individual(s) or organization(s) to whom disclosure is to be made: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Address: \_\_\_\_\_

2. Specific type of information to be disclosed: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

3. The purpose and need for such disclosure: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

4. This consent is subject to revocation at any time, except in those circumstances in which the Hospital has taken certain actions on the understanding that the consent will continue unrevoked until the purpose for which the consent was given shall have been accomplished. However, any consent given with respect to substance abuse records shall have a duration of no longer than that reasonably necessary to achieve the purpose for which it was given.

5. Without express revocation, this consent expires on the date set forth below or for the following specified reasons:

**CONDITION: Once information is disclosed, no further information can be disclosed pursuant to this consent.**

or Date: \_\_\_\_\_ or Event: \_\_\_\_\_ or None: \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient Date: \_\_\_\_\_ Phone No: \_\_\_\_\_

\_\_\_\_\_  
Signature of Parent, Guardian, or Personal Representative Date: \_\_\_\_\_ Phone No: \_\_\_\_\_

\_\_\_\_\_  
Signature of Witness Date: \_\_\_\_\_