AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I hereby authorize:____

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to release medical, psychiatric, drug use, alcohol abuse, HIV testing, ARC, or AIDS information* in the records of the patient named below for the purpose of medical care:

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I understand that this consent is revocable upon written notice, except to the extent that action has been taken in reliance on this authorization, and that this authorization shall remain in force for 5 years in order to effect the purpose for which it is given.

Alcohol and drug abuse information, if present, has been disclosed from records whose confidentiality is protected by federal law. Federal regulation 42 CPR part II prohibits making any further disclosure of it without the specific written consent of the undersigned, or as otherwise permitted by such regulations. HIV testing, ARC, and/or AIDS related diagnosis is further prohibited from further disclosure by state regulations without the specific written consent from the patient.

____
Date of Authorization

____
Patient's Name

________________________________ ________________________________
Patient's Date of Birth Patient's Social Security Number

____________________________________ __________________________
Signature of patient, parent, or legal guardian Relationship to patient

*Any of the categories above may be deleted by marking through

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For Office Use Only

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Physician/Office Manager Authorizing Signature

7/21/08