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# AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name: _____

DOB: _____ SSN: _____

For the purpose of continuing care I _____ Authorize _____ to release copies of the above identified patient's medical records, including medical, psychiatric care drug and alcohol abuse, and HIV/ AIDS / ARC related information to _____.

1. I understand that this consent includes and authorizes access to ALL OF THE IDENTIFIED PATIENT'S HEALTH INFORMATION. I also understand that this consent is voluntary and not required in order to receive services.
2. I understand this consent is revocable upon written notice. I also understand that the consent shall remain in force until revoked in writing.
3. I understand that this consent authorizes release of alcohol and drug information, if present.
4. I understand that this consent authorizes of psychiatric information if present.
5. I understand that this consent authorizes release of AIDS/ ARC information and/or HIV antibody testing/results, if present.
6. Please note that there will be a $1.00 per page charge on medical records released to parents that are picking them up for their own use.

_____ _____

Signature of Parent/Guardian Date

_____ (Relationship)

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