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Patient Name (Last, First, Middle): _____

Date of Birth: _____ Phone Number: _____

Address: _____

This authorization applies to all information. I understand that the information may contain psychiatric/psychological, alcohol/drug abuse, AIDS/HIV information and/or other sensitive health information for all treatment dates and I expressly consent to the release of all information.

THE INFORMATION MAY BE RELEASED AS FOLLOWS:

TO: _____ FROM: _____

ADDRESS: _____ ADDRESS: _____

_____ _____

PHONE: ( ) _____ PHONE: ( ) _____

I understand the information released will be limited to information necessary to fulfill the need or purpose for the disclosure. If I have authorized the disclosure of information to a recipient who is not subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), then the recipient may re-disclose it and it may no longer be protected under HIPAA, a federal privacy law. This authorization is valid for ninety (90) days from the date of signature, unless otherwise noted. This authorization only applies to treatment occurring before the date of signature. I understand I may see and copy the information described on this form if I ask for it, and I may receive a copy of this form after I sign it. Before requesting medical record copies, please ask about the copy fee by law that may apply. I represent that I have authority to and voluntarily grant permission for the information to be released and described above.

_____ _____

Parent/Legal Guardian (**PRINT NAME**) DATE Parent/Legal Guardian SIGNATURE

_____ _____

Patient Signature if 14 or older DATE Witness Signature DATE