PATIENT NAME _____

DATE OF BIRTH _____

ADDRESS_____

CITY_____**STATE**_____ **ZIP**_____

PHONE _____ **Email**_____

ADVANCED ADULT CLINIC

Authorization for Release of Health Information

I hereby authorize _____ **to release to**
(***Name and address of person / facility to release information***)

_____ **the following information:**
(***Name and address of person / facility to receive information***)

- ☐ All health information pertaining to my medical history, physical or mental condition, and diagnostics and treatments received; OR
- ☐ Only the following records or types of health information (including any dates):

  _____

I specifically authorize the release of the following information (check as appropriate):

- ☐ HIV / AIDS related information _____ (initials)
- ☐ Mental health treatment information _____ (initials)
- ☐ Alcohol and drug treatment information _____ (initials)

The purpose of this request for disclosure is: _____

Unless previously revoked by me, this authorization expires on (*date*): _____

*I have a right to receive a copy of this authorization.

*I may revoke this authorization at any time by writing to the provider at the following address: _____.
I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

* Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

_____ _____
Name and signature of patient or representative Date

_____ _____
Name and signature of witness (position/title if an employee) Date