

AUTHORIZATION TO RELEASE OR EXCHANGE INFORMATION AND RECORDS

Client/Applicant Name		Date of Birth:
Other Names		

I or my legally authorized representative request that confidential information and records about me be released or exchanged as set forth on this form:

Unilateral Release (Steps 1 – 3)

Mutual Exchange (Steps 1 – 6)

1. NAME AND ADDRESS OF PERSON, CLASS OF PERSONS, OR ENTITY AUTHORIZED TO RELEASE INFORMATION AND RECORDS:

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2. SPECIFIC INFORMATION AND RECORDS TO BE RELEASED:

<input type="checkbox"/> All Information/records	<input type="checkbox"/> Educational	<input type="checkbox"/> Social
<input type="checkbox"/> Medical/Dental	<input type="checkbox"/> Vocational	<input type="checkbox"/> Psychological
<input type="checkbox"/> Regional Center	<input type="checkbox"/> Other (specify):	

3. NAME AND ADDRESS OF PERSON, CLASS OF PERSONS, OR ENTITY AUTHORIZED TO RECEIVE INFORMATION AND RECORDS:

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4. NAME AND ADDRESS OF PERSON, CLASS OF PERSONS, OR ENTITY AUTHORIZED TO RELEASE INFORMATION AND RECORDS:

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5. SPECIFIC INFORMATION TO BE RELEASED:

<input type="checkbox"/> All Information/records	<input type="checkbox"/> Educational	<input type="checkbox"/> Social
<input type="checkbox"/> Medical/Dental	<input type="checkbox"/> Vocational	<input type="checkbox"/> Psychological
<input type="checkbox"/> Regional Center	<input type="checkbox"/> Other (specify):	

6. NAME AND ADDRESS OF PERSON, CLASS OF PERSONS, OR ENTITY AUTHORIZED TO RECEIVE INFORMATION AND RECORDS:

7. PURPOSE:

- Requested by client, applicant or legally authorized representative
- Other (specify):

I understand that the information released may also include the medical history, physical or mental condition, and services rendered or treatment received.

8. RIGHT OF REVOCATION. I understand that I have the right to revoke this authorization at any time, provided that my revocation is in writing.

9. LIMITS TO REVOCATION. I understand that my revocation will be effective upon its receipt by the person, class of persons or entity I authorized in Section 1, but would not be effective to the extent that such person, class of persons, or entity has acted in accordance with this Authorization and in reliance thereon. With respect to the person, class of persons or entity I authorized to receive information in Section 3, if I (or legally authorized representative) requested this Authorization, any revocation will be effective only when I (or legally authorized representative) communicate the revocation directly to them.

10. REDISCLOSURE. I understand that if a recipient of my information or records identified in Section 3 is not a healthcare provider, a health plan or health care clearing house or not an entity required to comply with federal or state privacy laws and regulations, my information may be further disclosed by such recipient and my information may no longer be protected by state and federal laws.

11. CALIFORNIA/ARIZONA RESTRICTION. I understand that a recipient of medical information in California or Arizona may not further disclose medical information about the patient unless a new Authorization form is signed by me or my legally authorized representative or unless disclosure is specifically required or permitted by law.

12. RIGHT TO REFUSE TO SIGN. I understand that I do not have to sign this authorization and that my failure to sign this authorization will not affect my ability to obtain treatment, payment or benefits.

13. DURATION. This authorization will automatically expire one (1) year from the date of signing unless a different end date or event date is specified below.

14. I understand that I must be provided a signed copy of this Authorization.

End date:	Event Name:
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Signature of client/applicant or legally authorized representative	Date
If signing on behalf of client/applicant, relationship to client/applicant:	