General Medical Records Release and Authorization for Use/Disclosure/Receipt of Protected Health Information

Client Name: _____ **DOB:** _____

I authorize the custodian of records,

_____,
(*Name of Facility or Provider disclosing information*)

to disclose/release the following information (check all applicable) to:

_____
(*Name of Facility or Provider receiving information*)

☐ Written Progress Notes
☐ Treatment Plans and Recommendations
☐ Verbal communication: Restrictions: _____
☐ Other: _____
☐ Abstract/Summary
☐ All records

These records are for services provided on the following date(s): _____

The information may be used/disclosed for each of the following purposes:

☐ At my request (only the client or authorized representative may check this box)
☐ For continuity of care
☐ For employment purposes
☐ For payment
☐ Other: _____

This authorization shall expire no later than: _____/_____/_____ or upon the following event: _____, whichever is sooner, and my not be valid for greater than one year from the date of signature. I understand that this information may not be released to any other organization without my permission. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment. By signing below, I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information. A photocopy of this authorization shall be considered valid.

_____ _____
Signature of Client (or Client's Personal Representative) Date

_____ _____
Printed Name of Client (or Client's Personal Representative) Relationship