Authorization for Release of Information

Patient's/client's name: _____ **Birth date** ___/___/_____
Last **First** **M. I.** **Mo. Day Year**

The undersigned hereby authorizes and requests

_____
Hospital, agent, or treatment program

to provide

_____
Name or title of person or organization to which disclosure is to be made

the following information: (please specify)

Discharge summary, admission information, psychosocial evaluation, psychosocial testing report, progress notes, and other relevant information: _____

_____

_____

Dates of Hospitalization: **all dates**

Dates of Services Provided: **all dates**

The disclosure is to be used for the following purposes: For obtaining Social Security disability benefits.

_____

This consent will expire one (1) year from the date hereof unless otherwise stipulated.

I understand that the information may/will include treatment for mental and/or physical illness, counseling or treatment for drug and/or alcohol abuse, human immunodeficiency virus (HIV), including acquired immunodeficiency syndrome (AIDS) or tests for HIV or AIDS.

I understand that I may revoke my consent to release information from my records, but not retroactive to release of information already made in good faith.

Signed _____ **Date** _____

_____ **Date** _____
Signature of Parent, Relative, or Legal Guardian, where applicable

Witness _____ **Date** _____

Any individual or agency receiving this information is prohibited from making further disclosure of this information.

If this information concerns a person admitted for treatment of alcohol or drug abuse, the confidentiality of this information is protected by federal law. Federal regulation (42 CFR part 2) prohibits you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information, if held by other party, is not sufficient for this purpose.
