**AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION**

Date of Request date \_\_\_\_/\_\_\_\_/\_\_\_\_ Expiration date \_\_\_\_/\_\_\_\_/\_\_\_\_ (One year from Request date if left blank)

Patient’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Name of recipient or legally authorized representative) hereby consent to and authorize you to release to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Person or Agency requesting Health Information)

Copies of: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date(s) of treatment: \_\_\_\_/\_\_\_\_/\_\_\_\_ - \_\_\_\_/\_\_\_\_/\_\_\_\_

This authorization is given for the sole purpose of: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes No

1. □ □ Are biological parents legally married? If No, continue to question 2.
2. □ □ Have biological parents ever been married? If yes, continue to question 3. If no continue to question 4.
3. □ □ Are biological parents divorced? If yes, continue to question 4.
4. □ □ Has either biological parent had legal rights pertaining to child revoked by court of law? If yes please provide legal documentation.

**Please allow for extra time when legal forms are required.**

*I understand that this authorization is subject to revocation at any time, except to the extent that the individual or entity that is to make the disclosure has already taken action in reliance upon it. I also understand and agree that this authorization will terminate only upon the execution of my written statement indication my intent to revoke this authorization and that without such written revocation, this authorization shall remain in full force and effect and shall not otherwise expire.*

Signature of Recipient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Relationship to Recipient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Copy driver’s license

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Staff Initials

**Provider to fill out:**

□ Legal Documents scanned into chart. INTLS\_\_\_\_\_\_\_ DATE \_\_\_\_\_\_\_\_\_

□ Records Faxed or Mailed. INTLS \_\_\_\_\_\_\_ DATE \_\_\_\_\_\_\_

□ Records picked up by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STAFF INTLS \_\_\_\_\_\_\_ DATE \_\_\_\_\_\_\_