Center for Prevention and Treatment of Infections
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Authorization to Release Confidential Information

I, _____, HEREBY AUTHORIZE

Person/Facility: _____

Address: _____

Phone #: _____ Fax #: _____

TO RELEASE MY CONFIDENTIAL MEDICAL RECORDS TO:
The Center for Prevention and Treatment of Infections, address above

INFORMATION TO BE DISCLOSED: (Initial each selection)

_____ General Medical Record(s), including STD and TB _____ Progress Notes _____ History and Physical Results

_____ Immunizations _____ Family Planning _____ Prenatal Records _____ Consultations

_____ Diagnostic Test Reports (Specify Type of test(s)) _____

_____ Other: (specify) _____

I voluntarily authorize and give my permission to allow disclosure of all my health information including any information about sensitive conditions. Records that may be released include all information regarding my health history, hospitalization, tests and outpatient care. This information may relate to sensitive health conditions including, but not limited to: Drug alcohol or substance abuse, Mental health or developmental disabilities (excluding psychotherapy notes), Sickle Cell Anemia, Birth control and family planning, Sexually transmitted disease, HIV/AIDS, tuberculosis, Genetic diseases or tests.

PURPOSE OF DISCLOSURE:

_____ Continuity of Care _____ Personal Use _____ Other (specify)_____

EXPIRATION DATE: This authorization will expire (insert date or event) _____. I understand that if I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.

REDISCLOSURE: I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

CONDITIONING: I understand that completing this authorization form is voluntary. I realize that treatment will not be denied if I refuse to sign this form.

REVOCATION: I understand that I have the right to revoke this authorization any time. If I revoke this authorization, I understand that I must do so in writing and that I must present my revocation to the medical record department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company, Medicaid and Medicare.

_____ _____
Patient/Representative Signature Date

_____ _____
Printed Name Representative's Relationship to Client

If patient representative is authorized to sign on behalf of the patient by virtue of a legal document, copy said document for placement in patient's medical record.

Patient Name: _____, DOB: _____ , MR #: _____

Based on DOH 3203, 1108 **Original:** To File **Copy:** To Client **Copy:** To Accompany Disclosure