NWF Health Network
Authorization for Release of Information

I, _____, hereby authorize the release of confidential information consisting of (*Psychiatric Records or Information, Psychiatric Medications, Drug/Alcohol Records or Information, HIV or AIDS Information, Medical Records or Information Medical Records or Information, Social History, Psychological Records or Information, Educational or School Records, Assessments, Service/Treatment Plans, All records of NWFHN, etc.).*

Whose Records are to be Disclosed (<u>print</u> name):

_____

First *Middle* *Last* *DOB*

Indicate the specific information to be released for the purpose of assisting with diagnosis, treatment, rehabilitation and/or delivery of other services:

_____

_____

_____

_____

From:

Individual/Organization:_____

Address:_____

To:

Individual/Organization:_____

Address:_____

I understand that my treatment, payment for services, enrollment in services or eligibility for services will not be affected by my refusal to sign this form.

I understand that the information that is released by signing this form may be further disclosed by the recipient and is then no longer protected by the Federal code as required by 45 CFR 164.508(c)(2)(iii).

This consent or authorization for release of information shall be effective the date of signature and shall expire one (1) year from the date of signature or may be revoked at any time, provided I notify the program in writing to this effect. Revocation has no effect on action previously taken.

SIGN SECTIONS THAT APPLY

CONSUMER

_____
Printed Name

_____
Signature

_____
Date

PARENT/GUARDIAN OF MINOR CHILD

_____
Printed Name

_____
Signature

_____
Date