Health Care for the Homeless

Authorization to Release or Obtain Health Information

(including paper, oral, and electronic information)

Name:	Request Date:
Mailing Address:	Date of Birth:
City/State/Zip:	Social Security #:

I authorize:

Name: _____

Mailing Address: _____

City, State, Zip Code: _____

Relationship: _____ Telephone Number: _____

❒ **RELEASE Information TO** **or** ❒ **OBTAIN Information FROM**

(Place an "X" in the box that indicates if the information is being released OR requested.)

Name: _____

Mailing Address: _____

City, State, Zip Code: _____

Relationship: _____ Telephone Number: _____

The **Purpose of this Authorization** is indicated in the box(es) below. *(Place an "X" in the box(es) that apply.)*

❒Further Medical Care ❒Personal ❒Legal Investigation or Action
❒Changing Physicians ❒Research related treatment
❒Creating health information for disclosure to a third party
❒Other:

(Specify)_____

I authorize the release of the following protected health information:

(Place an "X" in the box(es) that apply to the information you want released or you want to obtain.)

❒Entire Record ❒Medical History/Examination/Reports ❒Surgical Reports ❒Treatment or Tests
❒Prescriptions ❒Immunizations ❒Hospital Records including Reports ❒Laboratory Reports
❒X-ray Reports ❒MR/DD Records ❒Other: _____

In compliance with state and/or federal laws which require special permission to release otherwise privileged information, please release the following records:

❒Alcoholism ❒Drug Abuse ❒Mental Health ❒Vocational Rehabilitation ❒HIV (AIDS)
❒Sexually Transmitted Diseases ❒Genetics ❒Psychotherapy Notes
❒Other_____

This authorization shall expire on _____ (date or event) and is needed for the period beginning _____ and ending _____.

I understand that if I do not specify an expiration date, this authorization will expire six (6) months from the date on which it was signed. I acknowledge that I have read both pages 1 and 2 of this form. I authorize a copy (including electronic or faxed copy) of this form for the disclosure of the information described above.

_____ _____

Signature of Individual or Personal Representative authorized by law Date

_____ _____

Agency Witness Date