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Authorization for Use or Disclosure of Medical Information

Person receiving services

_____ __ __ / __ __ / __ __ __ __
Name **Date of Birth**

_____ (__ __ __) __ __ __ - __ __ __ __
Address **Home Phone Number**

Check the appropriate box to indicate what information may be used or disclosed:

a. All records ☐

b. Records specific to ☐ _____

Who you are authorizing to release your medical information:

_____
Name of provider/agency/person authorized to release information

Who you are authorizing to receive your medical information:

_____
Name of provider/agency/person authorized to receive information

_____
Address

In completing your acknowledgement you understand that:

- You do not have to complete this authorization and your refusal will not affect your benefits unless this authorization is necessary to determine your benefits.
- You have a right to receive a copy of this signed authorization.

_____ _____
Signature of person receiving services Date

_____ _____
Parent and/or Guardian (if applicable)* Date

*Minor Children must sign a release after 14 years of age.