Independent Management Services

Providing Human Services to Families in Southern Minnesota

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Authorization for Release of Information

Patient's/Client's Name: _____ Birth date:_____
Last First M.I. Mo./Day/Year

The undersigned hereby authorizes and requests

_____
Hospital, agent, or treatment program

to provide _____
Name or title of person or organization to which disclosure is to be made

the following information: (please specify): _____

_____

Dates of hospitalization: _____

Dates of services provided: _____

This disclosure is to be used for the following purpose(s):_____

_____

This consent will expire one (1) year from the date hereof unless otherwise stipulated.

I understand that the information may/will include treatment for mental and/or physical illness, counseling or treatment for drug and/or alcohol abuse, human immunodeficiency virus (HIV), including acquired immunodeficiency syndrome (AIDS) or test for HIV or AIDS.
I understand that I may revoke my consent to release information from my records, but not retroactive to release of information already made in good faith.

_____ Date:_____
Patient signature

_____ Date:_____
Signature of Parent, Relative, or Legal Guardian, where applicable

_____ Date: _____
Witness

Any individual or agency receiving this information is prohibited from making further disclosure of this information.

If this information concerns a person admitted for treatment of alcohol or drug abuse, the confidentiality of this information is protected by federal law. Federal regulation (42 CFR part2) prohibits you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information, if held by other party, is not sufficient for this purpose.