Authorization and Consent for Release of Client/Patient Records
Including for Release of Protected Health Information

Patient Information

Name:_____

Address: _____

SSN (last four digits): XXX-XX- _____

Telephone: (____) _____- _____

Email: _____

I am requesting that_____,
NAME OF RECORDS HOLDER

located at _____

_____,
ADDRESS OF RECORDS HOLDER

release a copy of my records. This request is being made for legal and personal use. I understand the information may be related to treatment for alcohol and/or drug abuse, psychological and psychiatricassessments and care, Acquired Immunodeficiency Syndrome, Human Immunodeficiency Virus, and otherwise private medical diagnoses, treatment, and history. I am requesting the release of all records, including but not limited to notes, treatment plans, laboratory results, imaging, photographs,and billing statements. This authorization is voluntary. This authorization may be revoked at any time by notifying the records holder in writing. I understand that my revocation will have no effect if the authorization has been relied on. I understand the risks associated with the release of this information, including by electronic means. I understand that if I redisclose any of the information released by the records holder, the information may no longer be protected under the HIPAA PrivacyRule.

I am requesting that, if possible, the information be released to me by the following:

☐ I will pick up the records from the office of the records holder.

☐ Mail the records to this address: _____
_____.

☐ Email the records to this email:_____.

This authorization expires on

☐ (*DATE*)_____or ☐ (*EVENT*)_____.

By signing below, I authorize the release of my confidential records and protected health information.

Client/Patient Printed _____

Client/Patient _____

Date _____