

AUTHORIZATION OF RELEASE OF INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____ City, State, Zip: _____

Phone Number: _____

I authorize McCallum Place to
Release information to:

AND/OR

I authorize McCallum Place to
obtain information from:

Name of Provider or Facility

Name of Provider or Facility

Address

Address

City, State, Zip

City, State, Zip

Phone #/Fax# (Include area code)

Phone #/Fax # (Include area code)

Purpose of this Request: _____

Specific Information Authorized (select one or more as appropriate):

- | | | |
|--|--|--|
| <input type="checkbox"/> Assessments | <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Laboratory/Medical Test Results |
| <input type="checkbox"/> Diagnostic Impression | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Treatment Plans |
| <input type="checkbox"/> Treatment Summary | <input type="checkbox"/> Dietary Information | <input type="checkbox"/> Other: _____ |

I understand that:

- I do not have to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment.
- I may cancel this authorization at any time by submitting a written request to McCallum Place, except where a disclosure has already been made in reliance on my prior authorization.
- Release of HIV-related information requires additional information.

Expiration of Authorization:

Unless otherwise revoked, this authorization expires _____ (insert applicable date or event). If no date is indicated, this authorization will expire 12 months after the date of signing this form.

Patient Signature

Date

Guardian Signature

Date

Witness Signature

Date