



Authorization to Release Confidential Information

Name _____ Date of Birth _____

Address _____ City & Zip Code _____

Section A: Complete this section to allow the Harris Family Center for Disability and Health Policy (CDHP) to disclose to another person or agency

I hereby authorize CDHP

To disclose information to (Name and address) _____

Relationship _____

Section B: Complete this section to allow CDHP to obtain information from another agency or program

I hereby authorize (name of person or agency) _____

Relationship (if person) _____

(Phone Number and Fax Number) _____

To Disclose Information (indicated in section C) to CDHP

Section C: Indicate the specific information that is requested or to be sent

Medical Records Specify _____

Therapy Records Specify _____

Verbal Communication Specify _____

Forms to be completed Specify _____

Other (explain): _____

Specific Purpose(s): _____

This authorization shall become effective (date) _____ and is subject to revocation by the undersigned at any time except to the extent that action has already been taken, and shall terminate twelve months from the effective date if not earlier revoked. I understand that this information will be used only for the purposes noted above and will not be disclosed to any other person or agency without my written permission. I understand that I have the right to receive a copy of this authorization upon request.

(Signature of Client)

(Date)

(Signature of CDHP Staff)

(Date)