Harris Family cdhp Center for Disability and Health Policy

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 (^{HF}CDHP) to disclose to a third party.

I hereby authorize ^{HF}CDHP to disclose information to

Name and Address ____________________

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____

Relationship ____________________

Section B: Complete this section to allow ^{HF}CDHP to obtain information from a third party. I hereby authorize (name of person or agency) ____________________

Relationship (if person) ____________________

Phone Number and Fax Number ____________________

To Disclose Information (indicated in Section C) to ^{HF}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 third party without my written permission. I understand that I have the right to receive a copy of this authorization upon request.

____________________ ____________________

Client Signature Date

309 E. Second Street, Bldg. 390, Pomona, CA 91766

Western University of Health Sciences