SSN (last four digits): XXX-XX-

Telephone: ( ) -

Email:

Address:

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

This authorization expires on

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

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

Appendix: Templates and Checklists

**Authorization and Consent for Release of Client/Patient Records**

**Including for Release of Protected Health Information**

**Patient Information**

Name: Prior name: Date of birth: / / \_\_

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 psychiatric assessments 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 Privacy Rule.



Mail the records to this address:



.

Email the records to this email: .



(*DATE*) or

(*EVENT*) .





Client/Patient Printed Name:

Client/Patient Signature:

Date Signed: