| I authorize |  |
| --- | --- |
| Address |  |
| To release: |  |
|  |  |
|  |  |
|  |  |  |  |
| About: |  |  |  |
|  | Patient |  | Date of Birth |
|  |  |  |  |
| To: |  |
| Attn: |  |
|  | (Name, Title) |
|  |  |
| For the purpose of: | *Continuity of Care* |
| This consent will expire of the following date, event, or condition: |  |
|  |
|  |

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year. Understand that I may revoke this authorization at any time and will be asked to do so in writing.

I understand these records are protected under Federal and State regulations and cannot be disclosed without my written consent unless otherwise provided for in the Regulations. The individual or agency to which the information is being sent is prevented from redisclosing this information to another party.

I understand that if my records contain information about HIV infection, AIDS or AIDS related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing, this disclosure will include that information.

Signing this authorization allows both parties to share information for the provision of services. I have the right to inspect and copy the information to be disclosed.

Revoking this consent will have no effect on prior disclosures made before withdrawal of consent.

|  |  |  |
| --- | --- | --- |
| Signature: Legally Responsible Person |  | Date |
|  |  |  |
| Signature: Personnel, Title |  | Date |
|  |  |  |
| Signature Authorization Revoked |  | Date |