**AUTHORIZATION AND RELEASE TO DISCLOSE MEDICAL RECORDS**

**INCLUDING HIV & AIDS RELATED INFORMATION**

Patient name: Date of Birth:

SS#: Purpose for disclosure: Court Ordered Investigation

I hereby authorize the use or disclosure of the above named individual’s health information as described below. The undersigned hereby authorizes \_\_\_\_\_\_\_ to make the disclosure of information.

Company/Persons Authorized to Receive Information:

The specific information to be disclosed is: Any and all records (including billing records), documents, reports, clinical abstracts, histories and charts, of any kind and description, related to care or services provided to the patient named above for the following dates: \_\_\_\_\_ .

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

This authorization will expire six months from the date on which it was signed. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

Patient Date Witness Date

If patient is unable to consent by reason of age or some other factor, state reasons:

Authorized Representative Date Relationship to Patient

Witness Date