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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, _____, agree to release my records from (party sending records):

To, (the party that is to receive the records):

This information is being disclosed for the following purposes (s) of:

I understand that this information may contain information relating to Acquired Immune Deficiency Syndrome (AIDS) or infection with Human Immune Deficiency (HIV), Mental Health, Alcohol, and/or Drug Abuse.

(DATE)

(PATIENT'S SIGNATURE)

(DATE)

(LEGAL GUARDIAN, IF PATIENT IS UNDER 18)

(DATE)

(WITNESS SIGNATURE)

NO INFORMATION CONTAINED IN THE MEDICAL RECORDS WILL BE GIVEN, SOLD, OR IN ANY WAY REALAYED TO ANY OTHER PERSON OR ENTITY NOT SPECIFIED IN THE CONSENT FORM WITHOUT FIRST OBTAINING THE INDIVIDUAL'S ADDITIONAL WRITTEN CONSENT ON A FORM STATING THE NEED FOR THE PROPOSED NEW USE OF SUCH INFORMATION OR THE NEED FOR IT'S TRANSFER TO ANOTHER PERSON OR ENTITY.

INFORMATION IS DISCLOSED IN CONFORMITY WITH THE LAWS OF CONFIDENTIALITY FORM ALCOHOL AND DRUG ABUSE AND MUST NOT BE RE-DISCLOSED (SEE FEDERAL REGISTER, VOLUME NO. 127, SUBSECTION C., PARAGRAPH 2.3, ISSUED JULY 1, 1975.

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