Heaven
Adult Foster Care

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AUTHORIZATION FOR RELEASE OF HEALTH RECORDS

I (Print name) _____ DOB: _____

Address: _____

Telephone: _____ Email: _____

I HEREBY AUTHORIZE THE RELEASE OF THE HEALTH RECORDS OBTAINED IN THE COURSE OF MY MEDICAL/MENTAL TREATMENT FOR THE LAST TWELVE (12) MONTHS required for the Coordination of Care:

Name of Physician/Facility: _____

Address: _____

Telephone: _____ Fax: _____

I specifically authorize release of drug, alcohol abuse, sexually transmitted disease, HIV diagnosis, tests or treatment of HIV and AIDS, and/or counseling/psychiatric records.

These records are protected under the federal regulations governing confidentiality and cannot be disclosed without your written consent.

I understand that this authorization is subject to written revocation at any time.

Member's Signature: _____ Date: _____