## AUTHORIZATION FOR RELEASE/ACQUISITION OF PATIENT INFORMATION

Local Health Department

The undersigned hereby authorizes \_\_\_\_\_

Whose address is			
To release to/or procure from _			
Information from the patient/cl	Facility Name inic record of:	Facility Address	
Name			
Birth da	te		
ID Num	ber		
	se, psychological or psychiat	ation which may include: HANDS, STD or tric conditions, or genetic testing, etcunlessen:	
for the purpose of _			
I understand that this authorization will expire on the following date, event or condition:			
period of time needed to fulfill transactions, wherein the author authorization at any time. I understand that my in information. I also understand my re	its purpose for up to one yearization is valid indefinitely.  formation may not be protect  fusal to sign this authorization	te or condition, this authorization is valid for ar, except for disclosures for financial. I also understand that I may revoke this ted from re-disclosure by the requester of to will not affect my ability to obtain treatry is requested by a party other than the patie	he ment,
1 •	•	his authorization may result in the service	1101
		o so I must send a written request to the Lo	ocal
I understand I can obtain to the Local Health Department		lata and to do so I must submit a written redized above.	quest
Signature of Client/Patient, Parent	or Legal Guardian	Date	
Relationship (if signature is not pa	tient/client)		
Signature of Witness  Only required when client/patient, parent or legal guardian signs by mark)			