Authorization for Release of Confidential Information

Client name: ____

DOB: ___________________________ SSN: __________________________________

Your signature on this form authorizes ____
(name of agency, person, etc.)

To release confidential record information to: ____
(individual or organization)

____
(address)

____
(city, state, zip code)

Description of information to be released: ____

____

____

This information is released in the form of: ☐ Verbal ☐ Written

The information is needed for ____
(purpose)

I understand that, by law, I need not consent to the release of this information; however, I choose to do so willingly and voluntarily for the purpose specified above. I further understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on my consent.

Client signature____Date_________________

Guardian signature____Date_________________

*This authorization is valid for a maximum of 60 days and is automatically void upon the following date or event:
____

Paladin Inc. workforce members shall be granted access to Protected Health Information (PHI), whether written, electronic or verbal in nature in accordance with the Health Insurance Portability and Accountability Act (HIPPA) and other state and federal laws. Such access shall be limited to the minimum necessary amount of PHI to accomplish their job or task. In addition, communications between workforce members which involve PFI shall also be considered confidential and should not take place in public areas.