PMD	**AUTHORIZATION FOR RELEASE OF INFORMATION**

Resident Name:		DOB:					
Address:						Phone#:	
City:		State:		Zip		Email:	

I authorize the release of my records (as identified below) to the following agency or person:							
Agency/Individual Name:							
Address:						Phone#:	
City:		State:		Zip:		Fax #:	

Select Record Format: ☐ Paper ☐ Electronic copy		**Select Record Type (check all that apply below):**
☐ Plan of Care	☐ Medications	☐ Discharge/Continuation Orders
☐ History & Physical	☐ Progress Notes	☐ Evaluations/Clinical Assessments
☐ Billing Records	☐ All Medical Records	☐ Other:

Specific Authorization: I understand for certain information to be disclosed, state and/or federal law requires my written authorization. Please initial to identify specific information to be disclosed.

_____ Alcohol/Drug diagnosis, treatment, or referral information
(Federal law prohibits the re-disclosure of such information)
_____ Psychosocial / Psychiatric / Psychotherapy information and/or records
_____ HIV / AIDS related health information and/or records

Requested Dates of Service: _____/_____/_____ to _____/_____/_____

Expiration: _____ / _____ / _____ Unless otherwise specified above, this authorization will expire one year from date signed.

I understand that this authorization in voluntary. Refusal to sign will not affect my ability to receive services. I understand that once my information has been released, it may no longer be protected. I understand that after I have signed this form, I may change my mind and revoke my consent by notifying this Covered Entity in writing and understand that the records may have already been released.

Signature of Individual (or Authorized Representative)			
Printed Name and Date of Person Signing		Date	
Authorized Representative Relationship's to Individual			