AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION FOR SPECIFIC PERIOD/ILLNESS

1. I Hereby authorize THE HICKEY WELLNESS CENTER to disclose the following information from the health records of:

   Patient Name: ____ Date of Birth_______________________

   Address: ____

   ____Telephone: _______________________

   Covering the period (s) of healthcare:
   From (date) ____________ to (date) _______________
   From (date) ____________ to (date) _______________

2. Information to be disclosed:

   _x__complete health record
   ____ history & physical exam
   ____consultation reports
   ____x-ray reports
   ____ discharge summery
   ____progress notes
   ____ laboratory tests
   ____photographs, video tapes, digital or other images
   ____ Other (please specify) ____

   I understand that this will include information relating to:
   __x__Acquired immunodeficiency syndrome (AIDS) human immunodeficiency virus (HIV) infection
   __x__Behavioral health service/psychiatric care
   __x__Treatment for alcohol and/or drug abuse

3. This information is to be disclosed to: ____
   For the purpose of: ____

4. I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance in this authorization. Unless otherwise revoked, this authorization will expire the following day, event or condition.

5. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability For disclosure of the above information to the extent indicated and authorized herein.

Signed: ____Date: ________________
(Patient)

Or ____Date: _________________
(legal representative) (relationship)