



**AUTHORIZATION TO OBTAIN/RELEASE/DISCLOSE
CONFIDENTIAL INFORMATION/RECORDS**

Name: (first, middle, last) _____

Date of Birth: _____

I hereby authorize the Lucas County Board of Developmental Disabilities

to obtain from: release/disclose to:

Name: _____

Address: _____

Identify information to be obtained or released/disclosed:

I understand that the information to be released includes: **(Initial where appropriate.)**

_____ Diagnoses and/or treatment for alcohol and/or drug abuse;

_____ HIV test results;

_____ AIDS/AIDS Related Complex (ARC) diagnoses and/or treatment;

_____ Diagnoses and/or treatment relating to other communicable diseases

Except with the following limitations:

PURPOSE FOR DISCLOSURE: (check one or more)

Service Coordination

Family Involvement

Legal Issues

Other _____

This authorization will remain effective until _____. **(Insert date of expiration or condition/event after which the authorization will expire.)**

I understand that I have authorized disclosure of protected information to persons who are not required by Federal or State law to keep the information confidential. These persons who are receiving the records may disclose the protected information to others without our consent or authorization.

Minor's signature (needed only if drug/alcohol treatment information is being disclosed):

Print Name: _____ Signature: _____ Date: _____

For Office Use Only:

Staff person releasing information:

Print Name: _____ Signature: _____ Date: _____

Date information released: _____

Revocation

I understand that I have the right to revoke/withdraw this authorization, in writing, at any time, and that the revocation/withdrawal will be effective except to the extent that action has been taken in reliance on my authorization.

I hereby revoke/withdraw my prior authorization to obtain or release/disclose confidential information/records.

Signature of Individual/Parent/Guardian: _____ Date: _____