RECORDS RELEASE AUTHORIZATION

I, _____, hereby give permission to:
(Print Name of Patient/Client)

_____
(Name of Agency Which is to Make the Disclosure)

to release from my files the following information:

☐ HIV Test Results

☐ CDC Report Form.

This information is to be released to:

_____
(Name/Title of Person/Organization to Which the Disclosure is to be Made)

The purpose or need for such disclosure is:

_____

_____

_____

A photocopy of this release has the force of and is as effective as the original.

_____
(Signature of Client/Patient)

_____
(Date)

_____
(Witness)

_____
(Date)