CONSENT TO RELEASE INFORMATION

I N S T R U C T I O N S

The individual obtaining a release of information form from a client will review the form with the client and insure that the person understands the content and purpose of the form.

PREPARATION

1. The name, social security number, address, date of birth, and day phone number of the person whose record you wish to have released appears here.

2. Complete with the name and address of the facility or physician releasing the information.

3. Complete with the name and address of the facility or agency the information is to be released to.*

4. This space is for the designation of the <u>specific</u> information being released; i.e. the specific items of information being released must be named as such; e.g., copy of nursing progress notes, physician notes, immunization forms, medical history forms, etc.

5. The purpose for which the information is to be used is to be explained here and must also be <u>specific</u>.

6. Date, event, or condition at which point consent will automatically expire (the time limit should be as brief as is possible with a period no longer than 60 days being recommended, however, certain agencies, facilities, or units may need a longer time allowance). This time limit should never be more than one year. Oral revocation is effective. It is recommended that an attempt be made to obtain written revocation.

7. This space bears the representative's signature. FORM SHALL BE COMPLETED PRIOR TO SIGNATURE AND SHALL BE DATED.

8. The signature of the minor Patient/Client is applicable if the minor has received treatment for substance abuse, venereal disease, pregnancy, abortion or family planning. However, it is recommended that the minor's signature be obtained in all cases, if possible.

9. Each signature shall be witnessed by at least one (1) witness.

*A separate consent form is required for each agency/facility to which information will be released.

FOSTER-JOHNSON HEALTH CENTER
GRAMBLING STATE UNIVERSITY
GRAMBLING, LA 71245
(318) 274-2351
FAX (318) 274 2481

For Office Use:	
Coded _____ Initials	_____ Date

CONSENT TO RELEASE INFORMATION
Waiver of Confidentiality Form

All information that has been gathered on an individual is personal and private, and you are not required to release this information. Such information cannot be released without authorized written permission, except as required by law.

I understand that the information in the record of:

Name: (1)		Social Security No.: (1)
Address: (1)	DOB: (1)	Day Phone No.: (1)
City: (1)	State: (1)	Zip Code: (1)

is personal and private. HOWEVER, I GIVE MY PERMISSION FOR:

Name: (2)		
Address: (2)		
City: (2)	State: (2)	Zip Code: (2)

TO RELEASE TO:

Name: (3)		
Address: (3)		
City: (3)	State: (3)	Zip Code: (3)

THE FOLLOWING SPECIFIC INFORMATION:

(4)

My medical record or the above listed information is to be released for the specific purposes of:

(5)

I understand that my permission to release this information may be canceled at any time except when the information has already been released. My permission to release this information will expire: (6) _____/_____/_____.

The undersigned certifies that he/she is the parent/guardian/representative of the person listed above and has the legal authorization to sign on behalf of the person, whether by court order, or by operation of law.

(9) Witness	Date	(7) Patient/Client	Date
(9) Witness	Date	(8) Parent/Guardian/Custodial Agency	Date

PLEASE ENCLOSE PICTURED IDENTIFICATION WITH YOUR REQUEST