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## STANDARD AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

### Client Information

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Hm Phone: \_\_\_\_\_ Wk Phone: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Soc Sec #: \_\_\_\_\_

### Information to be Used or Disclosed

I authorize Cedar River Clinics to release my medical records to any medical service provider that I may need as a result of the services provided at Cedar River Clinics. I authorize any provider of medical services necessary after services received at Cedar River Clinics to release my complete medical records to Cedar River Clinics. Those records shall extend to all aspects of treatment including testing and/or treatment for sexually transmitted diseases, substance abuse or mental health condition, unless expressly limited by me in writing.

I authorize the Cedar River Clinics to release the information described above except:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Expiration Date of Authorization

This authorization is effective for one (1) year from date of signing unless revoked or terminated by the client or the client's personal representative.

*I have received and read the privacy notice and I have been given ample time to ask questions regarding the information it contains. I understand Cedar River Clinics will hold my record to the highest standard of privacy and confidentiality and will only release my personal health information when so authorized by me in writing, or when required by law to do so.*

### Signature

Print Client Name \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

Signature of Client Representative \_\_\_\_\_

Relationship to Client \_\_\_\_\_