DEPARTMENT OF PUBLIC SAFETY & CORRECTIONAL SERVICES
REQUEST AND AUTHORIZATION TO RELEASE INFORMATION

Provider Request for Records Classification: ☐ **Routine** ☐ **Urgent**

PURPOSE To authorize the Department of Public Safety and Correctional Services to request and receive, and/or disclose the individual's health information.

I, _____
(Last Name, First Name, Middle – AKA)

_____ (Social Security #) _____ (Date of Birth) _____ (SID/DOC/Federal #)

_____
(Street Address) (City) (State/Zip)

Hereby consent to disclose my specified health information:

FROM (Sending Facility) **To** (Receiving Facility/Person)

_____ _____

_____ _____

_____ _____

Treatment Dates: _____

☐ History and Physical ☐ Laboratory Reports ☐ Consultation

☐ Mental Health ☐ Imaging Reports ☐ Other: _____

Purpose of the Disclosure:

This authorization is valid for one year and will expire one (1) year from the date signed below unless otherwise indicated on: _____ / _____ / _____ .
Month Day Year

I understand:

- This authorization is voluntary.
- I may revoke this authorization at any time by giving written notice of revocation.
- There may be a charge for copying and handling my request and that all fees will be in compliance with the applicable State guidelines.
- That once information covered by this authorization has been disclosed, re-disclosure of the information by that recipient is possible and the information may no longer be protected by the Federal regulations.
- I have read and understand the contents of this authorization, and I give my permission to request and receive, use, and disclose my health information.

_____ _____
Patient or Personal Representative Signature Date

_____ _____
Witness Date