

**AUTHORIZATION FOR USE/DISCLOSURE
OF INFORMATION**

Authorization for Use/Disclosure of Information

I, _____, born on _____, hereby voluntarily authorize
_____ to disclose my protected health and/or employment information from _____
to the present time, to the following **Recipient(s)/Requesting Evaluator(s)**

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Information to be disclosed: I authorize the release of the following information: (check the applicable box below)

- Any and all types of records you have for this patient
- Emergency room notes
- Urgent care notes
- History and Physical
- Discharge summary
- Psychological testing
- Hospital Progress notes
- Operation or procedure notes
- Clinical notes
- Lab reports
- Radiology reports
- Consultations
- Employment records

Purpose: I authorize the release of my information for the following specific purpose:

Forensic Evaluation

I understand that this Authorization will remain in effect

- From the date of this Authorization until the ____ day of _____, 20__.
- Until the Provider fulfills this request

and I can revoke this authorization at any time. I also understand that any information released for purposes of forensic evaluation may be included in a forensic report that is not confidential and available to relevant parties. By signing this form, I understand that I am entitled to receive a copy of this authorization but that revoking this authorization will not affect disclosures made or actions taken before the revocation is received. I acknowledge that the material authorized for release may contain information about substance abuse, psychiatric history, and HIV testing or results.

Signature of Evaluee

Date

Signature of Witness