AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, _____, hereby authorize
[Name of Employee (print or type)]

_____
[Name of DHS Official or DHS Organizational Unit requesting information]

_____
[Address and Phone Number of Requesting Official/Organization]

to obtain medical information from _____
[Name of Person or Organization holding information]

_____
[Address and Phone Number of Person/Organization holding information]

All medical information I hereby authorize to be obtained from this person/organization will be held strictly confidential and cannot be released by the recipient, with the exception of authorized personnel on a need to know basis, without my written consent.

I understand that unless otherwise limited by state or federal regulation, and except to the extent that action has been taken which was based on my consent, I may withdraw this consent in writing at any time.

_____ _____
[Date] *[Employee Signature]*