DELAWARE HEALTH AND SOCIAL SERVICES
DIVISION OF PUBLIC HEALTH
AUTHORIZATION FORM

Patient's Name:_____ Birth date:_____

I hereby authorize the release of information about me and/or my minor child (ren) to or from the below listed person(s) or agency (ies):

FROM:_____

TO:_____

ATTENTION OF: _____

RECORDS REQUESTED:_____

PURPOSE OF INFORMATION:_____

INFORMATION TO BE EXCLUDED:_____

If an HIV test was done, test results ☐ **are to be included** ☐ **are not to be included** in this release of information.

If there are psychotherapy and/or chemical dependency treatment notes in my record, the notes ☐ **are to be included** ☐ **are not to be included** in this release of information.

My signature indicates that I know exactly what information is being disclosed. For information from the Division of Public Health, I have had the chance to correct and change the information to make sure it is correct and complete. I am aware that this authorization can be revoked in writing at any time.

My signature also means that I have read this form and/or had it read to me and explained in a language that I can understand. All blank spaces have been filled in except for signatures and dates. I understand that any disclosure of my PHI carries with it the potential for redisclosure by the recipient and the PHI may not be protected by the federal privacy rules.

This authorization ends _____ (expiration date) unless revoked by me in writing before that time. This authorization is effective immediately and shall stay in effect as stated.

_____ _____
Patient's Name (Please print) Patient's Signature/Date

_____ _____
Parent/Guardian's Name (Please print) Guardian's Signature/Date

_____ _____
Witness's Name (Please print) Witness's Signature/Date

35-05-20/05/03/07
Revised 03.14.05