AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

I request and authorize Tom Woodward, LPC to release Medical records for:

Client_____DOB_____

To the following:

Name:_____

Address:_____

For the purpose of:

( ) Continuity of care.

( ) Other:_____

This request and authorization applies to :

( ) All healthcare information

( ) Specific healthcare information as indicated:_____

By INITIALING, I specifically authorize the release of the following confidential information:

_____HIV test, test results and related information.

_____Drug/Alcohol diagnosis, treatment or referral information.

_____Mental Health treatment information.

_____Relationship problems/difficulties.

_____ Other (specify)_____

This authorization is valid for one year from the date of signature unless cancelled by written notice by the client/legal guardian.

_____ _____ _____

Signature of client or legal guardian Relationship to client Date

_____ _____

Witness Date