**Signature:**

**Date:**

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**Effective Time Period:** If not previously revoked, this authorization will remain valid until the later of 10 days from the date signed below or...

**Authorization to Release/Who Can Receive and Use the Health Information:**

- [ ] General Information (including Genetic Test Results)
- [ ] Drug/Alcohol or Substance Abuse Records
- [ ] HIV/AIDS Test Results/Events
- [ ] Mental Health Records (excluding Psychotherapy Notes)
- [ ] All Health Information
- [ ] Lab Results
- [ ] Personal/Identification Name
- [ ] Treatment/Continuing Medical Care
- [ ] Medical Records (excluding Psychotherapy Notes)
- [ ] All Health Information
- [ ] Employee/Insurance
- [ ] Legal Purpose
- [ ] Billing or Claims
- [ ] School

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**Reason for Disclosure:**

- Choose only one option below:
  - Other
  - Employment
  - School
  - Disability Determination
  - Legal Purpose
  - Insurance
  - Billing or Claims
  - Treatment/Continuing Medical Care

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**Name of Patient or Individual:**

<table>
<thead>
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<th>First</th>
<th>Middle</th>
<th>Last</th>
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**Authorization to Release Health Information:**

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**Date:**

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**Signature:**