Sojourns
COMMUNITY HEALTH CLINIC

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

Name: _____

Former Name(s) if applicable: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____/_____/_____

I request and authorize: Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

To disclose the following information:

_____ lab work and results
_____ x-rays and results
_____ other, please specify _____

For the dates: _____

To be released and forwarded to: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

The reason for records release is:

_____ Coordination of care
_____ Transferring of Primary Care
_____ Other: _____

- I understand that this authorization will extend to all aspects of health care received, including but not limited to, diagnosis and/or treatment for sexually transmitted diseases and substance abuse.
- I understand that my medical records are protected under federal and state confidentiality laws and cannot be disclosed with out my written consent unless otherwise provided for by law.

_____ _____

Signature **Date**

Note: Records over 10 pages will need to be mailed.