

**Authorization for Release of Confidential Information** Date:

|  |
| --- |
| CLIENT PROFILE |

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| --- | --- | --- | --- |
| Regarding the records of: |  |  |  |

Last Name First Name Middle Name

|  |  |  |  |
| --- | --- | --- | --- |
| Date of Birth: |  | Social Security Number: | -     - |

(MM/DD/YYYY)

|  |  |  |  |
| --- | --- | --- | --- |
| AUTHORIZED AGENT OR ORGANIZATION | | | |
| Agency: |  | FAX: | (     )      - |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Address: |  |  |  |  |

Street City State Zip

|  |
| --- |
| AUTHORIZATION |

**I authorize the above named organization to  disclose to and/or  obtain from Employment Resources, Inc. (ERI), the following information from my records, including information about mental health (§ 51.30), alcohol and drug use/abuse (§ 93.282), HIV/AIDS test results, and developmental disabilities (send all information checked):**

**General Information**

Medical Records

Educational Records, including transcripts

Mental Health Records

Employment Records

Admission and Discharge Reports

Vocational Evaluations

Other (specify):

**Benefits Information**

SSI/SSDI

Medicare/Medicaid

County Economic Support

Other (specify):

**The purpose for this disclosure is to gather information for ERI Benefits Counseling Services.**

This authorization can be revoked at any time prior to the expiration date, except for that information already released with consent, which may continue to be used to complete action already taken. If you wish to revoke this authorization you must do so by writing to both ERI and the other agency or person listed on this form. You do not have to sign this authorization in order to receive services from the parties listed on this form. If the organization(s) and/or person(s) listed on this form are not subject to federal health privacy laws, the information they receive may lose its protection under those laws and thus be re-released without your permission.

This authorization expires **12 months** from today’s date on:

**Signature of Individual**: Date:

**OR** Signature of Person Legally Authorized to Sign on Individual’s Behalf:

Relationship to individual**:**