**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

1. I hereby request and authorize: Department of Children and Families ­­­\_\_\_\_\_\_\_\_\_

(Name of Person or Agency Requesting Information)

111 S. Sapodilla Avenue West Palm Beach, FL. 33401

(Address)

1. To obtain from:

(Name of Person or Agency Holding the Information)

1. The following information:

|  |  |  |  |
| --- | --- | --- | --- |
|  | All Medical Information and Reports |  | Immunizations |
|  | Prenatal Medical Records |  | X-Ray Reports |
|  | HIV Test Results |  | Physical Examination Records |
|  | Medical Data with WIC Certification |  | Laboratory Reports |
|  | Other (specify) To include any drug screens | | |

1. From the medical record of: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Name of Client, Birth Date, and File Number, if applicable)

1. For the purpose of: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. All information I hereby authorize to be obtained from this agency will be held strictly confidential and cannot be released by the recipient without my written consent. I understand that this authorization will remain in effect for ninety (90) days unless I specify an earlier expiration date here: (Date).
3. I understand that I may withdraw this consent at any time.

Date Signature of Client or Legal Representative

Witness Legal Representative’s Relationship to Client

1. **USE THIS SPACE ONLY IF THE CLIENT WITHDRAWS CONSENT**

Date Consent Revoked by Client Signature of Client