CORRECTIONAL MEDICAL SERVICES, INC.
RELEASE OF INFORMATION AUTHORIZATION

Name	ID Number/Date of Birth
Facility Releasing Information	Date

I am either the patient named above or the patient's legally authorized representative.

By signing this form I authorize and release Correctional Medical Services, Inc. ("CMS") and the Facility from liability relating to the release of the following information, including protected health information, included in my medical record to:

Name/Agency	Address	City, State, Zip Code

Information to be released	from the dates of		to		
	Admission Reports		Discharge Reports		X-Ray Reports
	Operative Summary Reports		Special Studies Reports		Laboratory Reports
	Immunization History		Mental Health Reports*		Psychiatric Summary Reports*
	Drug/Alcohol History and Counseling*		HIV Status and Treatment*		Sexually Transmitted Diseases Status and Treatment*
Other: Specify					

Purpose for which disclosure is being made:					
	Attorney		Insurance		Doctor
	Other: ___				

* I understand that my expressed consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, and/or drug and/or alcohol use. You are hereby specifically authorized to release all health care information relating to such testing, diagnosis, and/or treatment of the aforementioned conditions.

Signature of Patient or Authorized Representative	Date

I understand medical records cannot be disclosed without written consent, except as provided for under federal or state law. This authorization is valid for 90 days after the date signed and is subject to revocation by me at any time if provided in writing to CMS or the Facility, except to the extent that disclosure has already been disclosed in reliance on this authorization.

I understand I am not required to sign this authorization to receive health care or treatment. I understand that, once information is disclosed pursuant to this Authorization, it is possible that it will no longer be protected by applicable federal medical privacy laws and could be re-disclosed by the person or agency that receives it, however, I do not authorize such secondary disclosure.

State law provides that a health care provider may charge a reasonable fee for these records.

Signature of Patient or Authorized Representative*	Date Signed
*Authorized Representative's relationship to patient and authority to act for patient:	

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