CONSENT TO RELEASE
CONFIDENTIAL PATIENT INFORMATION

I hereby __ **authorize** __ **request** Women's Solutions LLC to **release to / obtain from**:

_____
_____
_____
Phone: _____ Fax: _____

my medical record information relating to:

□ diagnosis of/and treatment for medical conditions

□ diagnosis of/and treatment for alcoholism / drug use

□ diagnosis and/or treatment concerning mental health / rehabilitation

from the dates(s) of _____ through _____

Confidential HIV-related information is protected under PA law. The Confidentiality of HIV-related Information Act (35 P.S. 7607) requires written consent of the person to whom it pertains or is otherwise permitted by the ACT.

Drug / alcohol / mental health information is protected under Federal Confidentiality Law. Federal Regulations (42CRF Part 2) prohibit further disclosure of drug abuse patient records without written consent of the person to whom it pertains or is otherwise permitted by such regulation.

This consent may be revoked at any time **after** written notification is received, except to the extent that action has been taken, in reliance on this Consent. The Consent will automatically expire without the express revocation sixty (60) days from the date of my signature.

_____ _____
Client's Name (PLEASE PRINT) Date of Signature

_____ _____
Client's Signature Client's Date of Birth

_____
Client's Street Address

_____ _____
City State Zip Signature of Witness

If the client is a minor, mentally or physically disabled, or is deceased, the legally responsible party should sign and date this consent.

_____ _____
Signature of Parent / Legal Guardian Date

_____ Client **Accepted** Copy _____ Client **Refused** Copy