RELEASE OF INFORMATION

PATIENT'S NAME	PATIENT'S BIRTHDATE

I, _____, do hereby authorize
(PRINT NAME)

and request _____, to release
(PRINT NAME OF FACILITY, PHYSICIAN, OR OTHER ENTITY)

to _____ on behalf of the
(NAME)

State Department of Social Services and its agent,

_____, any and all records,
(NAME OF COUNTY)

reports, charts, examination and/or test results, notes, etc., concerning the examination and/or treatment and/or care of the above-named patient during the following time period: _____.

The disclosure of this information is required for the investigation and pursuit of administrative action in matters concerning a community care facility, a child care facility, or a facility for the elderly subject to licensure by the State Department of Social Services.

This authorization expires on _____, or six (6)
(DATE)

months from the date of signature, whichever is sooner.

Photocopies of this authorization shall be considered as valid as an original.
I understand that I may receive a copy of this authorization.

SIGNATURE	DATE	CHECK ONE
		☐ Patient ☐ Parent ☐ Domestic Partner ☐ Authorized Representative