

Altitude: Partnering with Families

A Horizon Cal, LLC Company

• 401 Alberto Way, Los Gatos, CA, 95032 • 408 353 0377

www.altitudefamilies.com

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF CLIENT HEALTH INFORMATION

I hereby authorize

Name of disclosing party:.

Address:

City: State: Zip:

Phone number:

to disclose to and exchange information with (caregiver)

Name of recipient party: Altitude: Partnering with Families

Address: 401 Alberto Way

City: Los Gatos State: CA Zip: 95032

Phone number:

records and information pertaining to (client)

Name of Client: Date of Birth:

Address:

City State: Zip:

Phone number:

Duration: This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here:

Revocation: This authorization is also subject to written revocation by the client at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization.

Redisclosure: I understand that the recipient may not lawfully further use of disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

Specify Records by initialing which type of information is to be disclosed:

Medical Information Psychiatric Information

Drug/Alcohol Information Results of HIV Blood Test

Other Health Information *Specify here:*

This consent is subject to revocation by the undersigned at any time except to the extent that information has already been released. Any request for revocation must be made in writing. Otherwise, this consent terminates on _____.

Signature of Client, Parent or Guardian

Date

Signature of Client, Parent or Guardian

Date