



Lake County
Court of Common Pleas
Juvenile Division

Judge Michael L. DeLeone

AUTHORIZATION TO RELEASE INFORMATION

(Please print or type)

I, _____
Client's Name Date of Birth

authorize _____
Facility Name Facility Address

to release (disclose) all information (except as restricted below) contained in my records to and receive information from:

Specific information: This authorization shall extend to all or any part of the medical record which may include treatment for physical and mental illness, alcohol/drug abuse, and/or HIV AIDS test results or diagnoses.

Other: _____

For the time period of: _____

Purpose and need for such disclosure: _____

This consent may be revoked by me, in writing, at any time unless already acted upon. This consent shall expire in 60 days from the date of signatures unless revoked by me, in writing, prior to action.

Client/Signature: _____ Date: _____

Parent/Guardian: _____ Date: _____

Witnessed by: _____ Date: _____

This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulation (42 CFR Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or otherwise permitted by such regulations. A general authorization for the release of information is NOT sufficient for this purpose.

S: Court Wide/Forms

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