Division of Immigration Health Services
Authorization for Release of Confidential Health Information

I hereby authorize ____
Name/Address
to disclose health information from my medical records.

Detainee Name/A#: ____

DOB: ____________________ Country of Origin: ____________________

Covering the period(s) of healthcare from ________________ to ________________
Date Date

Information to be disclosed:
☐ Complete Health Record ☐ H&P Exam ☐ Radiology Reports/EKGs

☐ Progress Notes ☐ Lab Reports ☐ Mental Health Notes/Evaluations

☐ Other ____
Specify

Reason for disclosure: ☐ Continued Care ☐ Lawyer ☐ Other ________________

I understand that this will include information relating to:
☐ Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV)

☐ Behavioral Health Services/Psychiatric Care

☐ Substance Abuse Records

This information is to be released via ☐ mail or ☐ facsimile to:

Name: ______________________________Phone/Fax #: ________________

Address: ____

City: ____________________ State: ________________ Zip Code: ____________

The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signed: ____
Detainee Name & Date
Legal Representative: ____
Name, Relationship & Date (if applicable)
Witness: ____
Name & Date

Medical records will only be faxed to another healthcare facility or medical provider

Form DIHS – 003
12/07