HEALTHY JOURNEYS, INC.

HEALTH INFORMATION RELEASE FORM

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary, and that I may revoke the authorization at any time by presenting my written revocation to *Healthy Journeys*. I understand that revocation will not apply to information that has already been released in response to this authorization.

In order to assist you in receiving your health information from *Healthy Journeys*, please complete this form.

I authorize the persons listed below to have access to any and all my health information, including HIV,drug and alcohol abuse, and psychiatric records. *Healthy Journeys* is permitted to share any medical information with them, including test results and information disclosed during office visits.

Persons Authorized to receive my medical information (full name and phone number):

You may notify me or the parties listed above with the test results, appointment reminders and any other information regarding my health as follows:

____ Message on answering machine Phone number _____

____ Message on work voice mail Phone number _____

____Message on pager Phone number _____

____Message on cell phone Phone number _____

____ Other _____

I understand and direct that this authorization will remain in effect until revoked by me in writing.

_____

Patient- Print Name **Date:** **Witness- Print Name**

_____

Patient-Signature **Date:** **Witness-Signature**

_____

Patient- Date of Birth **Patient Account #**