

Authorization to Disclose Health Information

I, _____, authorize _____ to release the information identified below to: _____ at _____ for the purpose of determining my eligibility for housing assistance.

- Your certification of my diagnosis of: _____
- Your certification of my minor child's (_____) diagnosis of: _____.
- Your certification of (_____) diagnosis of: _____.
- Other. (Be specific in the description of the information to be disclosed and the subject of that information - See attached sheet)

This authorization expires on the date you provide the requested information or two weeks from the date of this authorization whichever occurs first.

If I am authorizing you to disclose information about my minor children, my authorization is based on my capacity and authority as a custodial parent.

My authorization for you to disclose information about (_____) is based on my authority to act as their personal representative, as documented by the attached (_____) (Name of person Name of document)

Authorized Signature

Date

Print Name

Health Insurance Portability and Accountability Act of 1996 Disclosures

_____ may revoke this authorization by providing a written notice of (Name of borrower/household member)

revocation to _____, who is bound to comply with the (Name of person & company/agency holding medical information) request if the information requested in this authorization has not yet been provided.

_____ may not withhold treatment, payment, (Name of person & company/agency holding medical information)

enrollment, or eligibility for benefits if _____ does not sign (Name of borrower/household member)

this authorization. It is possible that the information disclosed using this authorization will be redisclosed by _____ and will no longer be protected by federal law. (Name of caseworker/lender)

However, state law prohibits _____ from disclosing this information without further authorization. (Name of caseworker/lender)