WOODS SERVICES
P.O. BOX 36
LANGHORNE, PA 19047

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use or disclosure of my Protected Health Information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Client Name: _____ Date of Birth: _____

Information is to be provided by:
WOODS SERVICES, PO BOX 36, LANGHORNE, PA 19047

Information is to be released to/shared with (name/address/phone number):

Specific description of information to be used, disclosed or shared:

I further authorize the release of information pertaining to: _____ Psychiatric/Psychological Treatment
(INITIAL EACH AS APPROPRIATE) _____ HIV Information

The purpose of releasing, using and/or sharing this information is:

I understand that I may revoke my permission at any time. If I wish to withdraw my permission **the request must be in writing** and sent to:

RECORDS SERVICES
Woods Services
PO Box 36
Langhorne, PA 19047

I understand that if permission is withdrawn it does not affect any information that was already released, used and/or shared.

Unless otherwise revoked, this authorization will expire on the date that I disenroll from Woods Services and its' subsidiaries.

_____ _____
Signature of client or client's representative Date

_____ _____
Printed name of client or client's representative Relationship to client

4/03
11/03R