

AUTHORIZATION TO COORDINATE SERVICES

Client Name: _____ DOB: _____

By signing below, I authorize _____ and any other individuals or agencies with whom I have signed a specific release of information, who have mutual interest in my case or treatment to participate in a discussion-only, relating to my care or treatment. Such discussions must be reasonably determined as necessary or pertinent to my care, treatment, or overall wellbeing.

I also authorize _____ to allow the Idaho Family Planning, STD & HIV Programs access to my records during site visits for quality assurance purposes, to assure that services are being provided according to the conditions of the Ryan White Part B contract.

This authorization does not permit the release of any client records or files without my expressed written consent. This authorization is valid for the duration of time that I choose to receive case management services from _____ and I reserve the right to withdraw this authorization at any time through written consent.

Date: _____

Signature: _____

Witness: _____

Client Address _____ City _____ State _____ Zip _____