

# **Appendix 9**

**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:

- |  |                                      |  |
|--|--------------------------------------|--|
| <input type="checkbox"/> Complete Health Record  | <input type="checkbox"/> H&P Exam    | <input type="checkbox"/> Radiology Reports/EKGs          |
| <input type="checkbox"/> Progress Notes  | <input type="checkbox"/> Lab Reports | <input type="checkbox"/> Mental Health Notes/Evaluations |
| <input type="checkbox"/> Other _____<br><span style="margin-left: 300px;">Specify</span> |                                      |  |

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**