center for life transitions

# Authorization for disclosure of Personal and Health Information

## Purpose

For the authorization to disclose personal information, which may include health information, to person's or organizations outside of an individual's support team. An individual's privacy is protected by state and federal privacy laws. As such, CFLT needs your explicit permission to make the requested disclosure. Please complete each section of this form.

## Your name and identification information:

Name:___________________________________________________________________________

Address:_________________________________________________________________________

City:______________________________________________State_______Zip Code________________

Telephone (____) ______-_________Email Address: __________________________________________

Date of Birth: ___/___/_____ Last 4 of your social security #__________________

To whom are we authorized to disclose your personal information?

Please state the names of the individuals or organizations, including contact information:

_________________________________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

Signature: ______________________________________________________________________

Guardian's Signature (if applicable): ________________________________________________

Date: __________________________

For questions about this authorization or to revoke this authorization, please contact:

Center for Life Transitions, 2324 Lake Ave, Ft. Wayne, IN 46805 260-201-1900