

WORKING WONDERS
P.O. BOX 3698
CATHEDRAL CITY, CA 92235-3698

AUTHORIZATON FOR RELEASE OF INFORMATION

CLIENTS NAME: _____ DOB: _____

 First Last (Mothers Maiden Name)

ADDRESS: _____

TELEPHONE #: _____ - _____ - _____ SOCIAL SECURITY # _____

I hereby authorize any and all medical and/or social providers, the release of patient information, to include demographic and medical diagnosis including HIV status, whenever requested by **“Working Wonders”**, {Hereafter **WW**) or its representatives. This authorization will allow the confidential exchange, gathering and /or access of information, on my behalf and/or behalf of my children, dependents and/or family members under my care.

I understand that communications/referrals may involve various social services, healthcare and/or other providers of services including, but not limited to, mental health, professionals, emergency centers, food programs, local, state and federal government agencies and financial institutions.

I understand that this authorization will allow **“Working Wonders”** to release information as needed to other agencies along with a referral for services on my behalf without further authorizations from me.

This authorization is to permit **“Working Wonders”**, or its representatives, when in possession of the original or a photo-static copy, to inspect, examine and photocopy all records pertaining to my diagnosis and my financial circumstances, or to permit those records to be copied and released to the **“Working Wonders”**.

I understand that the evaluation and/or services planning process may involve other members of my family and/or other professionals not specifically identified above, unless otherwise stated.

I authorize the use of **“Working Wonders”** letterhead on any and /or all correspondence necessary to effectively and efficiently evaluate, coordinate and plan my care and the care of my children, dependents, and /or family members.

I expressly waive my privacy rights under California Health & Safety Code 120975 and other applicable State and Federal law to permit the release to **“Working Wonders”** of information which may be protected by law.

I understand that as a client if I fail to show up to three appointments, mail is returned or telephone is disconnected and I am under a Ryan White funded program, I will be referred to a Riverside/San Bernardino County Ryan White “BRIDGE/Outreach” Program.

This authorization shall become effective immediately and shall remain in effect for one year from the date of signature and may be revoked at any time by submitting a written request.

CLIENTS SIGNATURE

DATE

STAFF

DATE