

404.874.4040 o [www.imaginehope.com](http://www.imaginehope.com) 404.874.3800 f

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Name of individual/client/patient Date of Birth

Authorization to Obtain & Release Information

I hereby authorize Imagine Hope, Inc. to obtain from/and release to:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name & Address of Partner Agency

the following information from my records:

\_\_\_\_\_\_\_\_\_\_ I authorize disclosure of information concerning my medical care and treatment for

Client Initials hepatitis C for the purpose of supporting my efforts to successfully complete treatment.

I hereby authorize Imagine Hope, Inc. to obtain from/and release to:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name & Address of Medical Provider(s)

the following type of information from my records:

\_\_\_\_\_\_\_\_\_\_ I authorize disclosure of information concerning my medical care and treatment for

Client Initials hepatitis C in support of my efforts to successfully complete treatment.

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Date Signature of individual/client/patient

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Medical Appointment Date Time Contact (please print)

USE THIS SPACE ONLY IF AUTHORIZATION IS WITHDRAWN

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Date this authorization is revoked Signature of individual or legally authorized representative