

**POLICY AND PROCEDURE CONCERNING CONFIDENTIALITY**  
**Appendix B**  
**CONFIDENTIAL INFORMATION RELEASE/REQUEST FORM**

I, \_\_\_\_\_, hereby authorize release/request of the following confidential information and/or health information about \_\_\_\_\_ as indicated below:

(In each case, state specific information and/or restrictions)

\_\_\_\_\_ Health records \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ Psychological/mental health records \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ Habilitation records \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ Finances \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ Publications \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ Other \_\_\_\_\_

\_\_\_\_\_

To: Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Telephone \_\_\_\_\_

I understand that the information used or disclosed may be subject to re-disclosure by the person or facility receiving it, and would then no longer be protected by federal privacy regulations.

I may revoke this authorization by notifying NorthStar Services in writing of my desire to revoke it. However, I understand that any action already taken based on this authorization cannot be reversed, and my revocation will not affect those actions.

This authorization expires one year from date signed or 30 days after termination of services provided by NorthStar Services.

A copy of this authorization shall be considered as effective and valid as the original.

Signature: \_\_\_\_\_

Date \_\_\_\_\_ Relationship \_\_\_\_\_

Witness \_\_\_\_\_

A copy of this completed form must be given to the individual and person signing on the individual's behalf, if applicable.