CONSENT FORM

THE RELEASE OF MEDICAL INFORMATION

Client Name: _____

For the purposes of this form, “my” and “I” mean the patient listed above whose record is maintained by High Impacto.

I hereby authorize High Impacto to release any and all health information that is contained in my records to other providers for treatment and as otherwise needed for my health and education at the sole discretion of High Impacto. I understand and acknowledge that this may include health information regarding HIV test results or diagnosis, treatment of AIDS/AIDS-related conditions.

If Authorization is not complete, signed and dated, it may be returned and result in my information not being released until completed.

_____ _____ / _____ / ____

Signature of Client Date Signed