

**AUTHORIZATION TO RELEASE  
HEALTH/MEDICAL INFORMATION**

I, \_\_\_\_\_, hereby authorize the medical care provider,  
(name of consumer)

\_\_\_\_\_,  
(name of institution, physician office or service provider)

\_\_\_\_\_,  
(address)

to release to \_\_\_\_\_, \_\_\_\_\_,  
(name of ISC agency) (address of ISC agency)

any and all records, including health and medical information, to assist my Independent Service Coordinator in assessing, coordinating and monitoring my care.

I understand that this authorization will remain in effect as long as I am a client of  
\_\_\_\_\_.  
(name of ISC agency)

A photocopy of this release shall be as valid as the original.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature  
D.O.B: \_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of ISC/Witness

