

AUTHORIZATION TO COORDINATE SERVICES

Client Name: _____ DOB: _____

By signing below, I authorize _____ and any other individuals or agencies with whom I have signed a specific release of information, who have mutual interest in my case or treatment, to participate in a discussion-only, relating to my care or treatment. Such discussions must be reasonably determined as necessary or pertinent to my care, treatment, or overall wellbeing.

I also authorize _____ to allow the Idaho STD/AIDS Program access to my records during site visits for quality assurance purposes, to assure that services are being provided according to the conditions of the Ryan White Title II contract.

This authorization does not permit the release of any client records or files without my express written consent. This authorization is valid for the duration of time that I choose to receive case management services from _____ and I reserve the right to withdraw this authorization at any time through written consent.

Date: _____

Signature: _____

Witness: _____

Client Address	City	State	Zip
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