

## Authorization for the Release of Information

I, \_\_\_\_\_, authorize the staff of the AIDS Care Project to allow the DPH Grantee or its designee access to and review of my client record. The sole purpose of review is for monitoring; to assure that ACP is in compliance with the requirements of the funding agency. I understand that the review will be visual only and that no records will be copied and no information identifying me will be recorded.

The authorization for release of information is for visual review only and in no way authorizes the Grantee or designee the right to remove information or collect personal identifiers.

This authorization has a 1 year duration from the date of signing below. I understand I am not required by law to consent to release this information, but choose to do so willingly and voluntarily. I understand I may revoke consent at any time except to the extent action has been taken in reliance of my consent.

Signed \_\_\_\_\_  
(Client)

Birth date: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Witness: \_\_\_\_\_

Date: \_\_\_\_\_