A Full Service, Licensed Child Placing Agency

AUTHORIZATION FOR RELEASE OF INFORMATION

Clients Name: ______________________________ AKA: ________________________
Address: ____
Date of Birth: ________________________ SSN: ______________________________
Phone: ______________________________ Other Phone Number:_________________

I HEARBY AUTHORIZE: ANY PHYSICIAN, MEDICAL FACILITY, PSYCHIATRIST, PSYCHOLOGIST, ADOPTION AGENCY, FEDERAL, STATE, COUNTY OR CITY AGENCY, ATTORNEY OR LAY PERSON OR TO RELEASE A COPY OF THE FOLLOWING INFORMATION:

Any and all psychiatric, psychological, health information, legal reports and /or documents, birth certificate records pertaining to me or any child of mine. Medical records may include information related to HIV, communicable disease, alcohol or drug abuse and mental health diagnosis and treatment.

You are hereby authorized to release to:

All for Love Adoptions, Inc.
2916 South 2000 West
Syracuse, Utah 84075
Phone: (801)525-2099 Fax: (801) 773-3638

Any and all psychiatric, psychological, health information or birth certificate records pertaining to me or any child of mine which is now or in the future may be in your possession or under your control, and are further authorized to freely verbally discuss any interaction you have had or may have with me.

It is expressly authorized hereby to copy or receive copies if any records or documents pertaining to me or the information specified above.

This information may be used in connection with any proceedings concerning the adoption, guardianship, custody, and the control of any child of mine.

You are authorized to release information to the individual or couple that adopts my child(ren), as identified by the "Placement Agreement" between All for Love Adoptions, Inc. and the adoptive party.

MEDICAID

I also authorize Medicaid to release information about me or my children to All for Love Adoptions, Inc. specifically, the Birthparent Coordinator and Director of the Adoption Agency. I authorized to give to them my Medicaid number and any other information about my case. I understand that if I apply for Medicaid in Utah, my benefits in another state will be cancelled.

CHILDS GENDER

I authorize the OBGYN, RN or Ultrasound Technician to tell All for Love Adoptions, Inc. the gender of my unborn child if requested, even if I choose not to know myself.

I also authorize and other adoption agency, counselor, attorney or other professional who is contracted by All for Love Adoptions, Inc. to release information about me, my child(ren), or this adoption to All for Love Adoptions, Inc. In addition, I authorize All for Love Adoptions, Inc. to release information about me to other adoption agencies if I have contacted them for assistance.

This Authorization shall remain valid for two years from this date.

______________________________ ______________

Name (please print) Date

Signature ______________________________

Section R501-2-8.9