OPOP AUTHORIZATION FOR RELEASE OF INFORMATION

NORTH DAKOTA DEPARTMENT OF HEALTH
OPTIMAL PREGNANCY OUTCOME PROGRAM
SFN 19513 (Rev. 10-2015)

Name		Birthdate	
Address	City	State	ZIP Code

CLIENT RELEASE AND SIGNATURE

I hereby authorize (Name and Address of Person/Agency)

To release information to (Name and Address of Person to Recieve Information)

The Following Information is Requested (Be Specific)

Indicate How the Information Identified Above will be Used (Be Specific)

This release of information consent remains in effect until

Date	or	Specific Event Terminating Operation of the Release

CLIENT CONSENT

This authorization is voluntary and reamins in effect until the above date or event, unless specifically revoked by written notice to the agency or person. Any information rleased prior to my written revocation of this authorization shall not be a creach of confidentiality. A photocpy of this release is as effective as the original.

Signature of Client	Date
Signature of Parent/Guardian or Custodian (if needed)	Date
Signature of Witness (if needed)	Date