PRINT CLEAR

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

I hereby authorize and direct _____
Name of Provider of Service

_____ _____ _____ _____
Street Address City State Zip Code

TO RELEASE FROM THE RECORD OF _____
Print Name Date of Birth

THIS INFORMATION IS TO BE SENT TO: _____

I UNDERSTAND THAT I HAVE THE RIGHT TO COPY AND INSPECT THIS INFORMATION BEFORE IT IS SENT.

☐ **I do wish to exercise this right. I reviewed this information on** _____ _____
Date Initials

☐ **I do not wish to exercise this right** _____
Initials

This consent is valid until _____**. I understand that I may revoke this consent in writing at any time.**

IF I REFUSE TO SIGN THIS CONSENT, I UNDERSTAND THAT THE FOLLOWING CONSEQUENCES MAY OCCUR:

Signature of * Patient _____ **Date signed** _____

Signature of * Parent _____ **Date signed** _____

Signature of * Guardian _____ **Date signed** _____

Signature of Witness _____ **Date Signed** _____

*** Persons who have power to sign: Patient, age 18 or over (or guardian): parent or guardian and patient 12–17 years: parent or guardian of a patient under 12 years.**

☐ **Original-Court File** ☐ **Copy-Plaintiff** ☐ **Copy-Defendant**