

# 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.