CONSENT FOR RELEASE OF INFORMATION

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I, _____ (Birth Date: _____)

Hereby authorize (Name) _____ (Phone/Fax): _____

(Address, City, ZIP): _____

□ To release specified information to

□ To exchange information with

(Name) _____ (Phone/Fax): _____

(Address, City, ZIP): _____

This Information will include:

□ All clinical relevant material

□ Other: _____

In particular: _____

I understand this information will be used for:

□ My clinical care

□ Other: _____

I understand the concept of informed consent. I understand the information to be released, the need for that information, and that there are statutes and regulations protecting the confidentiality of authorized information. I hereby acknowledge that this consent is truly voluntary. I further acknowledge that I may revoke this consent, in writing; at any time, except to the extent the action based on this consent has been taken.

This authorization expires:

□ Upon termination of treatment

□ One year from the date of authorization

□ _____

_____ _____
Signature of patient or legal representative Date

_____ _____
Relationship (if other than the patient) Witness signature