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CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, _____
(name of patient) (address, date of birth)

authorized _____
(name of person/organization **releasing** information)

to release to _____
(name of person/organization **receiving** information)

the following specific information:

_____

_____

_____

for the purpose of:

_____

I, the undersigned, understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it and that in any event this consent shall expire ninety (90) days after terminating treatment.

This consent will also expire under the following date, event, or condition:

_____

TO THE PARTY RECEIVING THIS INFORMATION: This information has been disclosed to you from records whose confidentiality may be protected by federal law. If so, federal regulations (42CFR, Part 2) prohibit you from making any further disclosure of it without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. A photocopy or facsimile of this authorization will be as valid as the original.

_____ _____
Date Signature of Patient

_____ _____
Witness Signature of parent, guardian, or Authorized Representative