

CONSENT TO RELEASE OF INFORMATION

NAME _____ Date of Birth _____

SSN _____ Claim # _____ Service # _____

I, THE UNDERSIGNED, HEREBY AUTHORIZE:

(Name and address of organization or individual from whom information is to be released.)

TO DISCLOSE AND/OR DELIVER TO:

(Name and address of person, Institution or organization.)

Only the following specific information from the subject records: (specify dates of service rendered). **(See reverse side for specific consents for mental health, substance abuse and or HIV/AIDS information.)**

I understand that this information is to be used (Reason for release of information) _____

I also understand that I may revoke this consent at any time by sending a written notice to the discloser of this information. I understand that any release which has been made prior to my revocation and which was made in reliance upon this authorization shall not constitute a breach of my rights to confidentiality. I understand I may review the disclosed information. This authorization will automatically expire one year from the date of signature, except as specified: _____
At that time no express revocation shall be needed to terminate my consent.

DATE _____ SIGNATURE _____

RELATIONSHIP _____

