CONSENT FOR DISCLOSURE OF MEDICAL INFORMATION

_____, _____ hereby consent to
(Patient's Full Name) (Birth Date)

and authorize _____
(Name of physician or Health Care Facility)

_____
(Street) (City) (State) (Zip)

to disclose to _____
(Specific Individual, Agency or Organization)

_____
(Street) (City) (State) (Zip)

information from my medical records relating to my identity, physical and mental health, history, diagnoses, prognosis and treatment. In compliance with those state statutes which require special permission to release otherwise privileged information, I understand that the records to be released may contain specific documentation of any mental illness, drug and/or alcohol abuse information we obtained from our patient during the specified dates of service.

Specify the type of information to be released, including dates and type of service: _____

_____

The purpose or need for disclosure: _____

_____

I understand that this consent may be revoked except to the extent that action has already been taken in reliance thereon, and that this authorization for disclosure will remain in effect for six (6) months from the date below, unless specifically terminated in writing and delivered to the party responsible for releasing the requested information beforehand.

_____ _____
(DATE) (SIGNATURE OF PATIENT)

_____ _____
(WITNESS) (PARENT OR LEGAL CUSTODIAN-RELATIONSHIP)

NOTE TO RECIPIENT OF INFORMATION: This information has been disclosed to you from confidential records, which are protected by law. Unless you have further authorization, laws may permit you from making any further disclosure of this information without the specific written consent of the patient or legal representative involved.