

## Consent to Release Confidential Information

I \_\_\_\_\_ hereby authorize and request,

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

to release confidential information, including personal, psychological, psychiatric, drug/alcohol, medical records and opinions, resulting from my contacts with the above to:

Name: \_\_\_\_\_

Title/Functions: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Disclosure shall be limited to the following specific types of information:

\_\_\_\_\_

\_\_\_\_\_

Use of this information shall be limited to the following purpose(s):

\_\_\_\_\_

\_\_\_\_\_

I understand that any cancellation or modifications of this authorization must be in writing, and that I have a right to receive a copy of this authorization. A photocopy of this authorization shall be as effective and valid as the original.

This authorization shall remain valid until: \_\_\_\_\_

I furthermore release all parties stated here within from any legal liability resulting from the release of this information, with the understanding that all parties involved will exercise appropriate safeguards while using this information

Signature \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_