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CONSENT TO RELEASE MEDICAL/PSYCHOLOGICAL INFORMATION

I, _____, understand that I am under no obligation to sign this

form and do hereby consent to and authorize_____

to disclose to_____

information from my medical or psychiatric records relating to my identity, diagnosis, prognosis or treatment compiled during my medical or psychiatric treatment(s) / hospitalization from _____ to _____.

I understand that the specific type of information to be disclosed includes: _____

_____
_

_____
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I understand that this consent may be revoked at any time in writing except to the extent that action has already been taken in reliance thereon, and that this authorization for disclosure will be effective until:

_____ (time or condition).

_____
(Signature of Patient OR

_____
Person Authorized by the Patient * and

_____ _____
(Witness) his/her relationship to patient.

Dated this _____ day of _____, 200____.

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

* NOTE: Person authorized by the patient means the parent, guardian, or legal custodian of a minor patient or a patient adjudged incompetent, the spouse or personal representative of a deceased patient, or any person authorized in writing by the patient which is witnessed and dated.