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Release of Information

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

I, ______________________ (Name of Client) ▲ , authorize ______________________ (Name of party to release information) ▲ to disclose information and records regarding

______________________ (Name of Client) ▲ whose Date of Birth is, __________ (D.O.B.) ▲ , to ______________________ (Name of party to receive information) ▲ .

SUCH DISCLOSURE SHALL BE LIMITED TO THE FOLLOWING SPECIFIC TYPES OF INFORMATION ▼

THE DISCLOSURE OF INFORMATION AND RECORDS AUTHORIZED HEREIN IS REQUIRED FOR THE FOLLOWING PURPOSE ▼

This authorization will be valid from __________ (Date) ▲ through __________ (Date) ▲ .

TYPED OR PRINTED NAME AND DATE ▼

______________________________ Date ▶ ______________

Handwritten signature (X) ▼

X _

X • Please sign and date this page.

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