CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, _____ authorize _____
(Name of Patient) (Name of Program which is to make disclosure)

_____ to disclose to _____,
(Name of person or organization to which disclosure is to be made)

the following information _____, for the
(Nature of Information)

purpose of _____.

I, undersigned, understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it and that in any event this consent shall expire 60 days after the date signed unless another date is specified.

Specification of the date, event or condition upon which consent expires.

_____

To the Party Receiving this Information: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or is otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. FOR PATIENT RECORDS APPLICABLE UNDER FEDERAL LAW 42 CFR Part 2.

_____ _____
Date Signature of Patient

_____ _____
Date Signature of parent, guardian or authorized Representative

_____ _____
Date Witness

FORM 027

Faxed or Mailed By: _____

Date: _____