AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

1. **Authorized Agent/Organization:**

   Name:

   Address: (Street):

   City, State, Zip:

   Attention:

2. **Regarding the Records of:**

   Name: (First, Middle, Last):

   Address:

   Birthdate:

   Social Security No.

3. **I authorize the above named agent or organization to disclose to:**

4. **The following information from my records:**

5. **The purpose or need for such disclosure is:**

6. This consent to disclosure of confidential information may be revoked by me at any time. If, at any time, I revoke consent, I understand that information already released with my consent may continue to be used to complete actions already initiated.

7. **This consent (unless revoked earlier) expires:**

8. This disclosure of confidential information is given with the understanding that the undersigned has a right to inspect and receive a copy of the material disclosed as required by law.

9. An electronically reproduced copy (xerox, facsimile, etc.) of this authorization shall be considered an original.

10. _____ _____
    Signature of Client/Patient Date

    _____ _____
    Signature of Parent or Guardian if Client/Patient is a Minor Date

    _____
    Relationship