John Callahan LCSWR

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CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, _____ authorize

(Patient Name) (PCP Name & Address)

to disclose to

(Provider Name, Address, Title of Provider Facility Program)

for the purpose of

(Medical Records)

The following information:(Nature of the Information)

I UNDERSTAND THAT MY RECORDS ARE PROTECTED UNDER FEDERAL AND STATE CONFIDENTIALITY REGULATIONS AND CANNOT BE DISCLOSED WITHOUT MY WRITTEN CONSENT UNLESS OTHERWISE PROVIDED FOR IN THE REGULATIONS. I ALSO UNDERSTAND THAT I MAY REVOKE THIS CONSENT AT ANY TIME EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN IN RELIANCE ON IT (E.G., PROBATION, PAROLE, ETC.) AND THAT IN ANY EVENT THIS CONSENT EXPIRES AUTOMATICALLY AS DESCRIBED BELOW.

Specification of the Date, Event, or Condition Upon Which This Consent Expires:

Executed This Day of 20

_____ Day of _____, 20_____

_____ _____

(Signature of Patient) (Social Security #)

(Signature of Witness)

Record of Informaton Released

(Signature of Staff Person Releasing Informaton)

_____ _____

(Title:) (Date Released)