

Consent to Release/Obtain Information:

RE (Client's Name):	
Date of Birth:	SSN #:
<u>I Hereby Authorize (Name of person/agency providing information):</u>	
<u>To release to/from (Name of person/agency requesting information):</u>	
The Following Information for Release:	
For the Purpose of:	

I do understand the nature of this release and freely give my consent. I understand that this release is valid for four years and may be rescinded in writing at any time.

Date:	Client/Patient Signature:
Date:	Witness:

This information has been disclosed to you from records whose confidentiality is protected by state law. State regulations limit your right to make any further disclosure of this information without prior written consent of the person to whom it pertains.

Please fill in the information then print the form, print the form, have your signature witnessed, and return the form to the Health Center.