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AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

PATIENT'S NAME: _____ BIRTHDATE: _____

I hereby give my permission for _____
to release any confidential information, verbal or written, regarding
the above-name individual to include:

Information to be released to:

I understand that the information obtained will be treated in a
professional and confidential manner, and will not be re-disclosed to
any other person or agency without the written consent of the above-
named person and/or parent or guardian.

This consent expires ninety (90) days from the date of the signature.

PATIENT'S SIGNATURE (if necessary)

DATE

PARENT OR GUARDIAN

DATE

WITNESS SIGNATURE

DATE