Hamsley Consulting

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CONSENT AND AUTHORIZATION TO RELEASE INFORMATION OR MEDICAL RECORDS UNDER THE PROTECTION OF FEDERAL LAW, TITLE 42, CFR CHAPTER II, PART II

Name:_____Sex:_____
First Middle Last

Date of Birth: ___/___/____ Social Security Number:_____

Pursuant to Federal Guidelines concerning my right to confidentiality,

I, _____

Authorize _____ to release

My medical records to: _____
Name of specific person(s) or organization(s)
I specifically consent only to the release of information or medical records

Pertaining to: _____
Specific nature, reason for, and extent of info to be released

I understand that I may revoke this consent to release information any time. However, I also understand that any release which has been made prior to my revocation and which was made in reliance upon this authorization shall not constitute a breech of my right to confidentiality. Unless I revoke this authorization prior to such time, this authorization or release information shall expire when:

_____
state date, event or condition or expiration

at which time no express revocation shall be needed to terminate my consent.

_____ _____
Patient's signature Date

If the patient is either under age or has a guardian appointed by the court, this release must be signed by the patient's parent or guardian.

_____ _____
Parent or guardian's signature Date

_____ _____
Witness Date