Consent to Release Confidential Information Pursuant to The Confidentiality of Medical Information Act By Patient

By signing this document, I, [Name of Patient] _____ hereby authorize

[Name and license number of provider of health care] NED DAVID BRATSPIS, MA, LMFT LF00002372

to disclose information and records obtained in the course of my diagnosis and/or treatment to [name and functions of the person or entity to whom disclosure is made] _____

_____

_____

I understand that I have a right to receive a copy of this authorization. I also understand that any cancellation or modification of this authorization must be in writing. This disclosure of information and records authorized herein is required for the following purpose: _____

_____

_____

The specific uses and limitations on the types of medical information to be disclosed are as follows:

_____

_____

_____

Such disclosure shall be limited to the following specific types of information: _____

_____

_____

_____

This authorization shall remain valid until: _____

Date: _____

Signature [of patient]: _____

**Note that this sample form can be altered to allow a legal representative of a patient, or a beneficiary or personal representative of a deceased patient to authorize the release of confidential information.