CONSENT FOR RELEASE OF INFORMATION

NAME: ____

DATE OF BIRTH: ______ / ______ / ______

SOCIAL SECURITY NUMBER: __________ / _________ / _________

I, ____, hereby authorize the recipient of this form to release any and all medical, social, psychological, educational or other information about me to____. I further authorize the person named above to release any information about me to any responsible individual, organization or agency.

I further agree that a photocopy of this release shall be as valid as the original.

This authorization shall remain in force until revoked by me in writing.

______________________________________ ______ / ______ / ______

Signature Date

Recipient: ____

Address: ____

____

Telephone: ____