**CONSENT FOR RELEASE OF INFORMATION**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, born on \_\_\_\_\_\_\_\_\_\_\_\_\_\_

SSN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to

disclose to Connexion Point Inc. the following information:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

The purpose of this disclosure is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

This authorization expires on: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, or whenever \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ is no longer providing me with services.

I understand that my records are protected under Federal regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it.

**Signature of Patient:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Dated:** \_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Witness:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Dated:** \_\_\_\_\_\_\_\_\_\_\_\_\_