



RELEASE OF INFORMATION

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____, hereby authorize _____
(Patient's name) (Name of Provider)

to release all information from my case records, as well as any other materials, documents or information pertaining to me, in the custody, command or control of the above named provider to RUANE ATTORNEYS for the purposes of legal representation. I also authorize the above named provider to discuss any of the contents of my records with these individuals and/or their duly authorized agents. This authorization includes, but is not limited to : Educational, Correctional, Employment, Military, Medical - including drug or alcohol abuse information and results of any HIV Test, Institutional, Judicial - including Juvenile Records, Probationary, Parole, Psychiatric/Psychological - including any information and/or records relative to alcohol or drug abuse or HIV positive diagnosis

This authorization is not restricted to time and includes any and all records incurred throughout my lifetime IN THEIR ENTIRETY.

I understand the my records are protected under State and Federal laws and Regulations and cannot be discussed without my written consent unless otherwise provided by law. I hereby authorize a photocopy of my consent to be as valid as an original. I also understand that I may revoke this consent at any time except to the extent that actions has been taken in reliance upon it.

Signature _____
Date of Birth _____
Date Signed _____

Subscribed and sworn before me, this _____ day of _____, 200__ at _____

Commissioner of the Superior Court
Authorized to Administer Oaths Pursuant to
Connecticut General Statutes §1-24(15)