PRISONERS' RIGHTS OFFICE
6 Baldwin Street, 4th Floor
Montpelier, Vt. 05633-3301
Tel: (802)828-3194 * Fax: (802)828-3163

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

TO: All medical and mental health physicians, providers, institutions and hospitals/_____:

I, _____, the undersigned, do hereby authorize the release of any and all records or information of any type in the custody of you or your office or institution with reference to: _____, to the:

Prisoners' Rights Office
6 Baldwin St., 4th Floor
Montpelier, Vermont 05633-3301

The purpose of the disclosure authorized herein is to assist counsel in representation.

I understand that my records are protected under the federal regulations governing Confidentiality of Patient records, 42 CFR Part 2, 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, and that in any event this consent expires automatically one year from the date of its signing.

A photocopy of this release shall have the same authority as the original.

DATED at _____, Vermont, this ___ day of _____, 2007.

✓_____
Signature

✓Date of Birth: _____