

Authorization for Release of Confidential Information

This form grants permission for the release of confidential information between specified parties, in accordance with applicable privacy laws and regulations.

Name of Individual/Entity Authorizing Release:**Date of Birth (if applicable):****Type of Information to be Released:**

e.g., medical records, financial data, academic records

Party Authorized to Receive Information:**Purpose of Release:**

e.g., insurance claim, legal proceedings, personal request

Authorization Effective Dates:**Special Instructions or Limitations (if any):**

I understand that this authorization may be revoked in writing at any time, except to the extent that action has already been taken based on this consent.

Signature of Individual/Authorized Representative:**Date:**

This form sample is provided for informational purposes only and should be tailored to comply with local and federal privacy laws (e.g., HIPAA, FERPA), as appropriate for the context of use.