Island Gift of Life Foundation, Inc.

P.O. Box 532
Shelter Island Heights., New York 11965

Date: _____

Patient Name: _____ Date of Birth: _____

Authorization for Release of Medical Records

I am aware that my medical records may have reference to a psychiatric, drug or alcohol problem and this authorization is intended to include permission to release any information pertaining to my treatment for any such problems, if contained in my medical records.

By authorizing the release of my medical or psychiatric records, I hold the Island Gift of Life Foundation, Inc., its physicians, agents and employees harmless from any consequences which I may suffer directly or indirectly as a result of the release of such records.

I understand that I can revoke this release at any time upon written notification to the Island Gift of Life Foundation, Inc. except to the extent that the Island Gift of Life Foundation, Inc. may have already released records in reliance upon this release, unless revoked, this release shall be in effect for (3) months from the date I sign this form.

_____ _____

Witness

Patient's Signature or signature of parents, guardian or other person authorized to consent for patient if a minor (under 18) or otherwise unable to give consent.

_____

Date Signed

_____ _____

Print Name (patient)

Relationship to Patient

If drug abuse or alcohol records are involved, this information is disclosed from records whose confidentiality is protected by Federal Law. Federal Regulation (42 CFR Part 2) prohibits redisclosure without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulation. A general authorization for the release of medical or other information will not be sufficient for this purpose.