Authorization for Release of Information
Midwest Brain Injury Clubhouse
Form 2:49A

I, _____
Member Name Date of Birth Social Security #

Authorize:_____
(Name of Program / person to disclose information to)

To Disclose To:_____

The following identifying information from my records:_____

_____

The purpose or need for such disclosure is:_____

_____

This consent expires in one year of signed date.

Signature of Member:_____Date:_____

Signature of Witness:_____Date:_____

By signing this form, the member acknowledges that the specified information to be released is confidential and protected by Federal and State law. This signed release waives their rights under these laws. This consent to disclose may be revoked by the above stated member at any time except to the extent that action has already been taken to release the information. Withdrawal of this consent must be made in writing to the Midwest Brain Injury Clubhouse.

Disclosure
This information has been disclosed to the recipient is considered confidential and protected by Federal law. The Midwest Brain Injury Clubhouse cannot guarantee that the recipient receiving the requested information will not disclose it to others. However, Federal regulations prohibit the recipient from making any further disclosure.