**AUTHORIZATION FOR RELEASE OF INFORMATION**

I hereby authorize and request any physician, hospital, clinic, institution, private facility/agency, or Federal or state agency/department having medical records or other confid4ential information pertaining to me to disclose such records to **McClain, Inc**. I give specific authorization for the release of any psychiatric or psychological information pertaining to me.

I, on behalf of myself for any other person who may have an interest in the matter, hereby release the physician, hospital, clinic, institution, private facility/agency, or Federal or state agency/department from all legal responsibility and liability that may arise from the act that I have hereby authorized.

It is understood that the above information, which is to be released to **McClain, Inc** is fully protected by the law’s establishing confidentiality of information acquired McClain, Inc. I further understand that this information will be used specifically for planning services designed for my benefit.

\*This release is valid for one year from the date of my signature. I understand that a photocopy of this document is as valid as the original.

**Signature of Consumer:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Guardian:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Guardian signature is required if the consumer is under 18 years of age or if the consumer has been adjudicated as being incompetent to act in his/her own behalf.)

**Witness (non-family member):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_