



**CONSENT TO RELEASE INFORMATION**

I, \_\_\_\_\_ hereby authorize

Name \_\_\_\_\_

Agency Name \_\_\_\_\_

Agency Address \_\_\_\_\_

Telephone Number \_\_\_\_\_

to exchange with or release the following of my protected health information to  
Transformational Sailing, 979 Golf Course Drive, #102 , Rohnert Park, CA 94928

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I understand that my records are protected under Federal Regulations governing confidentiality of patient records (42 CFR, II) and cannot be released without my written consent, unless provided for by law. I further understand I may revoke this consent at any time by making a written request which will become effective the date/time it is received. The specific uses of and limitations on the use of my health information by the recipient are as follows:

\_\_\_\_\_  
\_\_\_\_\_

The date, event or condition upon which this event expires, and/or other restrictions: \_\_\_\_\_

\_\_\_\_\_

**IF NOT DIRICTED BY ME THIS CONSENT SHALL CEASE TO BE LEGALLY EFFECTIVE OR BINDING TWELVE (12) MONTHS AFTER THE DATE BELOW:**

\_\_\_\_\_  
My signature

\_\_\_\_\_  
Date