



Willbur Consulting
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RELEASE OF CONFIDENTIAL INFORMATION

DATE: _____

I, _____ give Willbur Consulting and the providers listed below my consent to release and exchange the following information regarding any matter relevant to my case:

Probation/Court _____ Contact: _____
Address: _____ Phone No.: _____
Fax: _____ email: _____

Children's Services: _____ Contact: _____
Address: _____ Phone No.: _____
Fax: _____ email: _____

Domestic Violence Program: _____
Address: _____ Phone No.: _____
Fax: _____ email: _____

Mental Health Provider: _____
Address: _____ Phone No.: _____
Fax: _____ email: _____

Attorney: _____
Address: _____ Phone No.: _____
Fax: _____ email: _____

Other: _____
Address: _____ Phone No.: _____
Fax: _____ email: _____

I understand that I have the right to revoke any part of this release at any time. This release will automatically expire one year from today's date. I intend that my authorization for the release of records and information related to my health care comply with and fulfill all requirements under the privacy standards (45 CFR Part 160) as implemented under Section 264 of the Health Insurance Portability and Accounting Act of 1996, P.L. 104-191 ("HIPAA").

Signed: _____ Phone: _____