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Arizona State Board of Nursing

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CONSENT FOR RELEASE OF INFORMATION

I, _____, born _____, hereby
Full Name of Client/Participant **Date of Birth**

request and authorize the Arizona State Board of Nursing to disclose to

_____, _____
Name **Address**

the following information related to my treatment for _____

(Nature of Information to be Disclosed)

I understand my records may be protected under Federal Confidentiality Regulations and records related to diagnosis and treatment of mental health/chemical dependency conditions cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that this consent expires automatically when the above request has been fulfilled.

EXECUTED THIS _____ DAY OF _____, 2010.

Signature of Client/Participant